



Keystone at a Glance

Thank you for your interest in Keystone Center for Children with Autism, Inc. We hope you find the application process to be straightforward and trouble-free. We look forward to working with you and your family to create a learning environment that best meets your child's needs.

Our mission...

First, we are dedicated to the educational and social development of children with Autism Spectrum Disorder. Second, we are committed to providing support and training to families affected by Autism. We utilize the most recent scientifically validated methods to provide individualized, comprehensive, and state-of-the-art treatment to maximize the communication, independence, and competence of children with Autism. We believe that every child is capable of learning and that families should have the support they need to raise their child with confidence.

- Keystone Center for Children with Autism, Inc. is a non-profit, 501(c)(3) organization.
- We teach students with Autism Spectrum Disorder (ASD), including PDD-NOS and Asperger Syndrome.
- All intervention strategies utilize the principles of Applied Behavior Analysis (ABA) and the Analysis of Verbal Behavior (AVB).
- Each student's goals are developed based on an initial evaluation (which includes the Assessment of Basic Language and Learning Skills – Revised). These goals are revised and updated as needed based on the student's progress.
- We maintain a 1:1 student-teacher ratio (with some opportunities for small group instruction).
- Staff receive extensive, ongoing training and are evaluated regularly to ensure outstanding performance.
- Parent training is offered regularly on a variety of topics including toilet training and behavior management. (Parents of students enrolled at Keystone are required to attend 3 out of the 4 offered workshops in order to maintain enrollment.)
- We offer a half-day or full-day program based on the age and needs of the student.
- We provide a year-round program of instruction.



Application for Admission

Keystone Application Checklist

Please gather the following materials into a packet and send them together to the address below. (Do not send information separately.)

- _____ Application Form - must be submitted with a non-refundable application fee of \$100 (Make checks payable to Keystone Center for Children with Autism, Inc.)
- _____ Recent photograph of the Applicant
- _____ Reinforcer Inventory
- _____ Observation Consent Form
- _____ Photo / Video Consent Form
- _____ Consent for Release of Education Records
- _____ Medication Consent Form
- _____ Copy of current Psychological and/or Neurological Report(s)
- _____ Immunization Records

If applicable:

- _____ Most recent Progress Report
- _____ Current IEP / IFSP
- _____ Functional Behavioral Assessment (FBA) and summarized behavior data
- _____ Graphic summaries from prior ABA programs
- _____ Most recent assessments / evaluations: including ABLLS / ABLLS-R, medical, communication, OT, PT, speech, etc.
- _____ History of behavioral medications from prescribing psychiatrist

After receipt of required documents, Keystone staff will contact you to verify the documents were received. Once the application and supporting documents are reviewed, Keystone staff will contact you to schedule an observation in the Applicant's current placement (i.e., home, school, etc.).

If you have any questions about the program, application materials, or procedures please contact Ann Lane at 404-496-4673 or ann.lane@keystoneatlanta.org.



Application for Admission

Anticipated enrollment date (month) _____ (year) _____

Today's Date _____

Applying for Full Day _____ Half Day _____

General Applicant Information

Name of Applicant _____ S.S. # _____

Last

First

Middle

Preferred Name _____ Birthday _____ Age _____ Male _____ Female _____

Address _____

City _____ State _____ Zip _____ Telephone _____

Ethnicity _____ Primary Language _____

Current School District _____ Current School _____

Present Grade _____ Primary Diagnosis _____

Mother's Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Fax Number _____ Email _____

Father's Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Fax Number _____ Email _____

Emergency Contact _____ Relationship to Applicant _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

General Family Information

Mother _____ Age _____

Last

First

Maiden

Birthday _____ SS# _____ Highest Level of Education Completed _____

Employer _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____

Marital Status _____ Married _____ Separated _____ Divorced _____ Remarried _____ Widowed _____ Single

What talents, resources, interests, or professional skills would you, as a parent/guardian, be willing to share with Keystone Center for Children with Autism, Inc.? Please describe. _____

Father _____ Age _____

Last

First

Middle

Birthday _____ SS# _____ Highest Level of Education Completed _____

Employer _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____

Marital Status _____ Married _____ Separated _____ Divorced _____ Remarried _____ Widowed _____ Single

What talents, resources, interests, or professional skills would you, as a parent or guardian, be willing to share with Keystone Center for Children with Autism, Inc.? Please describe. _____

With whom does the Applicant reside? _____

IF CHILD DOES NOT LIVE WITH PARENTS IN ONE HOUSEHOLD, PLEASE COMPLETE THE FOLLOWING:

Step-Father Step-Mother Other _____ Step-Father Step-Mother Other _____

Name _____ Name _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

Permission to share Applicant's information with the above. Permission to share Applicant's information with the above.

Siblings / Others in Household:

Name

Birthday

Relation to Applicant

Current School



Current Medications:

If the Applicant is *currently* taking any medication, please list.

Drug _____	Dosage _____	Start Date _____
Purpose _____	Reaction(s) _____	
Drug _____	Dosage _____	Start Date _____
Purpose _____	Reaction(s) _____	
Drug _____	Dosage _____	Start Date _____
Purpose _____	Reaction(s) _____	
Drug _____	Dosage _____	Start Date _____
Purpose _____	Reaction(s) _____	

Past Medications:

If the Applicant has taken any other medications in the *past*, please list.

Drug _____	Dosage _____	Start Date _____
Purpose _____	Discontinue Date _____	
Reason(s) for Discontinuing _____		
Drug _____	Dosage _____	Start Date _____
Purpose _____	Discontinue Date _____	
Reason(s) for Discontinuing _____		
Drug _____	Dosage _____	Start Date _____
Purpose _____	Discontinue Date _____	
Reason(s) for Discontinuing _____		
Drug _____	Dosage _____	Start Date _____
Purpose _____	Discontinue Date _____	
Reason(s) for Discontinuing _____		

Note: Important information for parents!

1. If your child is currently receiving medication, it is imperative that you are accurate in identifying the medication and the dosage prior to admission.
2. Upon admission, you must again identify the exact medication and the dosage that your child is receiving.
3. Whenever there is a change of medication, Keystone staff must be notified in writing 24 hours prior to the change.
4. Changes that occur without notification to Keystone Center for Children with Autism, Inc. put the student at risk and Keystone reserves the right to make placement decisions based on changes.
5. You will be required to sign a medication consent prior to your child's admission and annually once enrolled.

I have read and understand the above information. _____
Signature of Parent/Guardian
Date



Immunizations:

Please indicate the date the Applicant received the following immunizations (or attach form).

	Date		Date
DPT Initial Series	_____	Chest X-Ray	_____
DPT Boosters	_____	Mumps	_____
DPT or Tetanus Booster	_____	Polio (Salk/Sabin) Initial Series	_____
Smallpox	_____	Boosters	_____
Measles	_____	Hepatitis Vaccine Series	_____
Rubella (German Measles)	_____	Pneumovax	_____
TB Skin Test	_____	H-Flu	_____

Illnesses:

Has the Applicant had any of the following? (If yes, please state the date.)

	Yes	No	Date
Chicken Pox	_____	_____	_____
Diphtheria	_____	_____	_____
Rubella (German Measles)	_____	_____	_____
Measles	_____	_____	_____
Mumps	_____	_____	_____
Pneumonia	_____	_____	_____
Scarlet Fever	_____	_____	_____
Strep / Sore Throat	_____	_____	_____
Small Pox	_____	_____	_____
Whooping Cough	_____	_____	_____
Tuberculosis	_____	_____	_____
Diabetes	_____	_____	_____
Cardiac Defect	_____	_____	_____
Kidney / Bladder Infections	_____	_____	_____
Ear Infections	_____	_____	_____
Hepatitis	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Doctor Information:

Primary Physician's Name _____ Date of Last Physical Exam _____
Last First Middle

Specialty _____ Office Phone _____

Address _____

City _____ State _____ Zip Code _____

Hospital Affiliation _____

Other Specialist Name _____ Date of Last Appointment _____
Last First Middle

Specialty _____ Office Phone _____

Address _____

City _____ State _____ Zip Code _____

Hospital Affiliation _____ Reason for Evaluation _____

Other Specialist Name _____ Date of Last Appointment _____
Last First Middle

Specialty _____ Office Phone _____

Address _____

City _____ State _____ Zip Code _____

Hospital Affiliation _____ Reason for Evaluation _____

Education History

Current Services:

Please indicate the services the Applicant is *currently* receiving (or school/program that was last attended).

_____ Public School (K-5) Name of School _____ Grade _____

Name of Principal _____ Name of Teacher _____

Services: OT _____ PT _____ Speech _____ Other _____ Has a current IEP _____

_____ Private School Name of School _____ Grade _____

Name of Principal _____ Name of Teacher _____

Services: OT _____ PT _____ Speech _____ Other _____ Has a current IEP _____

_____ Preschool or Daycare Name of Program _____

_____ Home School Provided by School _____ Provided by Therapist _____ Provided by Parents _____

_____ Early Intervention Program Services _____



Current Therapies: (speech therapy, physical therapy, occupational therapy, etc.)

Type of Therapy _____ Frequency _____ Approximate Start Date _____

Therapist's Name _____ Phone Number _____

Type of Therapy _____ Frequency _____ Approximate Start Date _____

Therapist's Name _____ Phone Number _____

Type of Therapy _____ Frequency _____ Approximate Start Date _____

Therapist's Name _____ Phone Number _____

Type of Therapy _____ Frequency _____ Approximate Start Date _____

Therapist's Name _____ Phone Number _____

School History:

Please list, beginning with the most recent, all schools in which the Applicant has been enrolled.

Name of School _____

Address _____ City _____ State _____ Zip Code _____

Dates Attended From _____ To _____ Grades Covered _____

Briefly describe reason for leaving _____

Name of School _____

Address _____ City _____ State _____ Zip Code _____

Dates Attended From _____ To _____ Grades Covered _____

Briefly describe reason for leaving _____

Name of School _____

Address _____ City _____ State _____ Zip Code _____

Dates Attended From _____ To _____ Grades Covered _____

Briefly describe reason for leaving _____

Has there been any difficulty with the Applicant's behavior in a school situation? If so, please describe briefly: _____



Behavior

The following are questions related to problematic behavior that the Applicant may demonstrate as well as current and/or previous interventions used. Please indicate the behaviors that have occurred over the last 6 months and describe.

_____ Physical Aggression (Any attempt to come in contact with another person with force using either their own body or an object. i.e., hitting, kicking, biting, throwing objects at)

Has physical aggression resulted in injury? _____ Yes _____ No

Describe this behavior. _____

How often does this behavior occur? _____ Hourly _____ Daily _____ Monthly _____ Rarely

Are there situations in which the behavior is **most** likely to occur? _____

Are there situations in which the behavior is **least** likely to occur? _____

Please describe in detail some of the previous and current interventions used. _____

Are/were any of these interventions successful at reducing the behavior? _____ Yes _____ No

_____ Self Injurious Behavior (Any attempt to cause injury to themselves. i.e., head-banging, biting self, poking eyes)

Has self injurious behavior resulted in injury? _____ Yes _____ No

Describe this behavior. _____

How often does this behavior occur? _____ Hourly _____ Daily _____ Monthly _____ Rarely

Are there situations in which the behavior is **most** likely to occur? _____

Are there situations in which the behavior is **least** likely to occur? _____

Please describe in detail some of the previous and current interventions used. _____

Are/were any of these interventions successful at reducing the behavior? _____ Yes _____ No



_____ Self Stimulatory Behavior (i.e., rocking, hand-flapping, repeating vocalizations)

Has self stimulatory behavior resulted in injury? _____ Yes _____ No

Describe this behavior. _____

How often does this behavior occur? _____ Hourly _____ Daily _____ Monthly _____ Rarely

Are there situations in which the behavior is **most** likely to occur? _____

Are there situations in which the behavior is **least** likely to occur? _____

Please describe in detail some of the previous and current interventions used: _____

Are/were any of these interventions successful at reducing the behavior? _____ Yes _____ No

_____ Property Destruction (Any attempt to destroy items. i.e., throwing objects, tearing books, tipping tables)

Has property destruction resulted in injury? _____ Yes _____ No

Describe this behavior. _____

How often does this behavior occur? _____ Hourly _____ Daily _____ Monthly _____ Rarely

Are there situations in which the behavior is **most** likely to occur? _____

Are there situations in which the behavior is **least** likely to occur? _____

Please describe in detail some of the previous and current interventions used: _____

Are/were any of these interventions successful at reducing the behavior? _____ Yes _____ No

Please indicate any other behaviors that have occurred in the last 6 months that may interfere with learning or make the Applicant less successful at home.

- | | | |
|-----------------------------------|--------------------------------|---------------------------|
| _____ Attention Seeking Behaviors | _____ Noncompliance | _____ Yelling / Screaming |
| _____ Throwing / Dumping Objects | _____ Elopement / Running away | _____ Whining / Crying |
| _____ Spitting | _____ Other: _____ | |



Functional Skills

Is the Applicant verbal? Yes No If no, how does the Applicant communicate? _____

Mobility:

- Uses stairs
- Uses slide
- Uses swing
- Swims

Self-Help:

- Keeps room clean
- Makes bed
- Hangs clothes in closet
- Folds clothes
- Puts clothes in drawers
- Prepares sandwich

Leisure:

- Operates television
- Operates remote control
- Uses computer
- Uses computer mouse
- Uses touch screen

Social:

- Gets along with siblings
- Gets along with peers
- Needs close supervision
- Disrupts group activities

Eating:

Does the Applicant currently have a feeding/eating disorder? Yes No

Does the Applicant have any of the following feeding problems? Please indicate all that apply.

- Food Refusal (Refuses all or most foods.)
- Food Selectivity by Type (Eats only a narrow variety of foods. i.e., only eats French fries and goldfish crackers)
- Food Selectivity by Texture (Eats only specific textures. i.e., only eats smooth or crunchy foods)
- Oral Motor Delays (problems with chewing, lip closure or tongue lateralization)
- Dysphagia (problems with swallowing)
- Abnormal Preferences (e.g., refuses food if not a certain temperature, eats only certain brands, must have a certain utensil or a certain dinnerware to eat)
- Other Feeding Problems (please describe _____)

Toileting:

Is the Applicant toilet trained? Yes No

If no, have you begun toilet training? Yes No If yes, indicate start date _____

Does that Applicant currently wear diapers? Yes No

If yes, indicate when diapers are worn At all times At night only Other, specify:

If previous attempts to toilet train have been unsuccessful, please describe the methods used. _____



Parent Expectations

Please state your **Vision Statement** for your child.

Please describe your **Short Term Goals** for your child.

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe your **Long Term Goals** for you child.

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe your concerns with your child's current placement.

1. _____
2. _____
3. _____
4. _____
5. _____

How did you learn about Keystone Center for Children with Autism, Inc.? _____



Parent Participation Agreement

Keystone Center for Children with Autism, Inc.'s mission is two-fold. First, we are dedicated to the educational and social development of children with Autism Spectrum Disorder. Second, we are committed to providing support and training to families affected by Autism. We believe that every child is capable of learning and that families should have the support they needed to raise their child with confidence. Your participation in this process is paramount to the success of your child. If your child is accepted into Keystone's program, you will be expected to attend all team meetings regarding your child's progress. Keystone will provide quarterly training workshops for parents covering a variety of topics related to Autism. You will be expected to attend 3 out of 4 of these workshops. Keystone Center for Children with Autism, Inc. reserves the right to reconsider your child's enrollment if these requirements are not satisfied.

If you have any questions or comments regarding this application, you may contact us at 404-496-4673.

I affirm that all information included in this application is true and correct. I understand that all requests for admission to Keystone Center for Children with Autism, Inc. are subject to approval by the Admissions Committee. I also understand that the information contained herein will be used for admission consideration. I give my permission for the Admissions Committee to contact any of the above contacts for the purpose of gathering information that would assist in the admissions process of the applicant.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

Please send the completed application to:

Keystone Center for Children with Autism, Inc.
 1676 Fair Oak Way
 Mableton, GA 30126

Keystone Center for Children with Autism, Inc. admits students of any race, color, national origin, and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national origin, and ethnic origin in administration of its educational policies, admission policies, scholarship and loan programs, and athletic and other school-administered programs.

Keystone Center for Children with Autism, Inc. is a non-profit, 501(c)(3) organization.



Observation Consent Form

Current School / Program Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Student Information

Name _____

Last

First

Middle

Address _____

City _____ State _____ Zip Code _____

Phone _____

I, the undersigned, hereby authorize Keystone Center for Children with Autism, Inc. staff to observe the above named child in his/her classroom/program. I further grant permission for the school/program personnel to discuss with and provide the staff of Keystone Center for Children with Autism, Inc. with all relevant information and records pertaining to my child's academic and behavioral performance, including assessment findings and recommendations.

This authorization is valid only for the facility to which this form has been addressed and will expire only if revoked by myself. I understand that I may revoke this authorization, in writing, at any time. A photocopy of this signed form is acceptable and may be honored as the original.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date



Photo / Video Consent Form

Consent is hereby given to Keystone Center for Children with Autism, Inc., with approval of _____,
Parent/Guardian
 to take videotape and photographs of _____. These photographs and video will be used
Student Name
 for the purposes of staff training, publications, marketing, research, and program development. Video and photographs will only be
 of students and staff participating in typically-occurring classroom activities while at school or in community settings. Keystone
 Center for Children with Autism, Inc. will also accept any video or photographs which parents choose to provide to Keystone.

I understand that I have the right to view all video and photographs collected by Keystone staff. If I wish to do so, I will notify the
 Executive Program Director in writing.

I further consent to give Keystone Center for Children with Autism, Inc. the right and permission to use my name, my child's name,
 and/or my written or spoken words for reproduction in any publication or media prepared by Keystone.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date



Consent for Release of Education Records

I understand that a student's education records are confidential and may only be disclosed as allowed by the Family Educational Rights and Privacy Act of 1974, or with the written permission of the student's parent or legal guardian.

I request that _____ County Public Schools provide copies of all education records for the following student:

Student's full name (as it appears on the education records)

Student's Date of Birth

Please list the name and address of the person(s) receiving education records:

1. _____
Name

Address

2. _____
Name

Address

3. _____
Name

Address

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date



Medication Consent Form

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medication at school, all appropriate portions of this form MUST be completed before medication can be given at school. One form for EACH medication is required.

Student Name				
Type of Medication		Start Date		End Date
Dosage		Frequency		
Possible Side Effects				
If PRN (as needed), describe conditions under which to administer				

Permission is given to the school to administer an early A.M. dose of medications, if forgotten at home (per parent/guardian request).

Parent / Guardian Consent:

(Complete for all prescription and non-prescription medication/procedures at school.)

- I request and authorize that this medication be administered at school, by school personnel.
- I will supply medication in its original, updated, properly labeled containers.
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I understand that when medication at school is no longer needed, an adult must pick up remaining medication. *It will not be sent home with the child.*
- I understand that all medication should be delivered to the school by a parent/guardian.
- I understand that medication will be given by non-medically trained school personnel.
- I agree to hold Keystone Center for Children with Autism, Inc., its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

Physician Name _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Physician Signature

Date

1675A Hembree Road
Alpharetta, GA 30004

Phone: 404-496-4673
Fax: 404-496-4674
ann.lane@keystoneatlanta.org

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Individual: _____

Date: _____

Person Completing Form: _____

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
A. Food Items					
1. Candy (What kind?)					
a.					
b.					
c.					
2. Raisins					
3. Cereals					
4. Nuts					
5. Chips					
6. Cake					
7. Cookies					
8. Beverage (What kind?)					
a.					
b.					
9. Ice Cream (What kind?)					
a.					
b.					
10. Other Food Items					
a.					
b.					
c.					
d.					
e.					
f.					
g.					

Reinforcement Inventory

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Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
B. Entertainment					
1. Watching Television (What shows?)					
a.					
b.					
c.					
2. Movies					
3. Music					
4. Going to Events (Which events?)					
a.					
b.					
5. Bike Riding					
6. Skating					
7. Table Games					
8. Coloring/Painting					
9. Video Games					
10. Other					
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					
i.					
j.					
k.					

Reinforcement Inventory

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Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
C. Arts/Crafts					
1. Playing an Instrument					
2. Singing					
3. Dancing					
4. Drawing					
5. Building Models					
6. Others					
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					
i.					
j.					
k.					
l.					

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
D. Excursions					
1. Ride in Car					
2. Visit Relatives/Friends					
3. Picnic					
4. Lunch/Dinner Outing					
5. Go to Store					
6. Go for a Walk					
7. Amusement Park					
8. Go to a Mall					
9. Others					
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					
i.					
j.					

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
E. Social/Interactions					
1. Social Praise (By whom?)					
a.					
b.					
c.					
2. Being Hugged					
3. Being Touched					
4. Group Activities					
5. Talking with Others					
6. Time Alone (With whom?)					
a.					
b.					
c.					
7. Others					
a.					
b.					
c.					
d.					
e.					
f.					
g.					

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
F. Domestic Activities					
1. Setting Table					
2. Making Bed					
3. Sweeping					
4. Dusting					
5. Outside work					
6. Cooking					
7. Shopping					
8. Menu Planning					
9. Running Errands					
10. Exemptions from Chores					
11. Others					
a.					
b.					
c.					
d.					
e.					
f.					
g.					

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
G. Personal Appearance					
1. New Clothes					
2. Costumes					
3. Getting Haircut					
4. Having Picture Taken					
5. Others					
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					
i.					
j.					
k.					

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
H. Sensory Stimulation					
1. Smells					
2. Colors					
3. Noise Makers					
4. Cold					
5. Warm					
6. Wet					
7. Rocking					
8. Others					
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
I. Other Events/Activities					
1. Reading					
2. Being Read to					
3. Books/Magazines					
4. Discussing Current Needs					
5. Math					
6. Money					
7. Having Free Time					
8. Pet					
9. Bath/Shower					
10. Decorating Room					
11. Choosing Bedtime					
12. Others					
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					
i.					
j.					

Reinforcement Inventory

Instructions: The items in this questionnaire refer to things and experiences that may give a person joy, satisfaction, and/or pleasurable feelings. For each item, activity, and event, check one option in the columns below that indicates how much this individual "enjoys" the described item, activity, or event.

Description of Potentially Reinforcing Items, Activities, and/or Events	Not at All	A Little	A Fair Amount	Much	Very Much
J. Tokens					
1. Star Chart					
2. "Happy Faces"					
3. Badges					
4. Certificates					
5. "Honor Roll"					
6. Token Accumulation					
7. Points					
8. Money					
9. Gift Certificates					
10. Tickets					
11. Others					
a.					
b.					
c.					
d.					
e.					
f.					