WHATCOM takingaction for Children and Youth with Special Health Care Needs (CYSHCN)

Applied Behavioral Analysis (ABA) Intake Form

If your child has an autism diagnosis, OR is 6 and under and on a wait list or has an appointment for an autism evaluation, you may fill out the intake form to get on the waitlist for ABA Therapy. Please, be sure to keep a copy for yourself noting the date you sent it.

FAX or MAIL the completed intake form and documents listed below to any or all of the Whatcom County ABA providers on whose wait list you'd like to be included. Feel free to contact providers to get up-to-date wait time and service information.

☐	AUTISM IMPROVEMENT SERVICES INC	**Autism Improvement Services. INC** 955 3rd Street #201, Blaine, WA 98230 Phone: (206) 751-6155 | Fax: (360) 526-2916
☐	Balanced Behavior ABA, PLLC.	**Balanced Behavioral ABA** Based in Whatcom County Phone: (360) 684-4566 | Fax: (360) 326-2205
☐	Bayside Autism Therapies	**Bayside Autism Therapies** 1311 11th Street, Bellingham, WA 98225 Phone: (206) 825-0251 | Fax: (844) 384-9206
☐		**BFS Behavior Solutions** Phone: (425) 999-5010 | Fax: (360) 393-4944
☐	Endless Potential	**Endless Potential** 5711 Vista Drive #100, Ferndale, WA 98248 Phone: (360) 746-4092 | Fax: (877) 205-5744
☐	pbs	**Positive Behavior Supports Corporation** Phone: (855) 832-6727 | fax: 772-675-9100
☐	SpringHealth Behavioral Health & Integrated Care	**SpringHealth Behavioral Health & Integrated Care** 414 West Bakerview Road, Suite 101, Bellingham, WA 98226 Phone: (425) 673-6905
☐	SENDAN CENTER	**Sendan Center** 4201 Meridian Street, STE 113, Bellingham WA 98226 Phone: (360) 305-3275 | Fax: (360) 734-5503
☐	SPROUT CLUBHOUSE	**Sprout Club House** 310 East Magnolia Street, Suite 101, Bellingham, WA 98225 Phone: (360) 820-5835

Please enclose the following documents if available. These will be required prior to the start of services.

- ☐ Copy of your insurance card
- ☐ Copy of current IEP or IFSP
- ☐ Diagnostic report with the DSM V checklist (must be from a designated Center of Excellence for Apple Health / Molina)
- ☐ Prescription letter for ABA (for Apple Health / Molina)
- ☐ Copy of parenting plan

Please indicate if the family need an interpreter

☐ Language_____

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H17MC28297, Healthy Tomorrows Partnership for Children Program for $49,075 (66% is financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Fill out the following intake form and fax or mail it to any or all of the ABA providers listed on page 1. Keep a copy for yourself. Note the date you sent it to the ABA providers.

Child Information

Last Name:	**Today's Date:**
First Name:	**Date of Birth:**
Middle Name:	**Age: years months**
Home Phone:	**Gender:**
Address:	**City:**
State: Zip: County:	**Race/Ethnicity:**
Language Primarily Spoken in the Home:	

Child's Primary Health Care Doctor

Doctor's Name:	**Phone:**

Autism Diagnosis Information

If your child does NOT have an autism diagnosis, but IS on a waiting list or has an appointment for an autism evaluation, please fill out the line below:

No appointment, but on wait list for evaluation with:

Has appointment with: on this date:

If your child HAS an autism diagnosis, please fill out the line below:

My child was diagnosed by: **Phone number of person who diagnosed:**	**Date of diagnosis:**

Health Care Coverage Information

Primary Coverage for ABA:

☐ **DSHS/DDA/CIIBS Waiver**

☐ **Apple Health/Medicaid**

If so, which plan? ☐ **Molina** ☐ **Community Health Plan of WA** ☐ **Coordinated Care** ☐ **United Healthcare Community Plan**

☐ **Private Health Insurance**

If so: Insurance company name:

Please complete the following OR attach a copy of primary insurance card

Plan Name	**Policy #**	**Group#**
Subscriber (Name of Insured)		**Subscr's DOB**
Place of employment		

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Secondary Coverage for ABA:

☐ DSHS/DDA/CIIBS Waiver

☐ Apple Health/Medicaid

If so, which plan? ☐ Molina ☐ Community Health Plan of WA ☐ Coordinated Care ☐ United Healthcare Community Plan

☐ Private Health Insurance

If so: Insurance company name:

Please complete the following OR attach a copy of secondary insurance card

Plan Name	Policy #	Group#
Subscriber (Name of Insured)		Subscr's DOB
Place of employment		

Who has current custody/guardianship of child?

☐ both parents ☐ mother ☐ father ☐ relative: ☐ other:

If there is a parenting plan, please provide a copy.

Your availability for ABA appointments (Check all that are possible)

☐ Weekdays, during school hours:

Morning ☐ M ☐ T ☐ W ☐ Th ☐ F Afternoon ☐ M ☐ T ☐ W ☐ Th ☐ F

☐ Weekdays, after school hours: ☐ M ☐ T ☐ W ☐ Th ☐ F

Mother or Legal Guardian Information

Full Name:	Relationship to Child:
Address: (if different from child)	Cell Phone:
	Home Phone:
Email:	

Father or Legal Guardian Information

Full Name:	Relationship to Child:
Address: (if different from child)	DOB:
	Cell Phone:
City:	Home Phone:
State:	Business Phone:
E-mail:	Occupation:

If applicable, please fill in below

Stepmother's Name:	Phone: (h) (w)
Stepfather's Name:	Phone: (h) (w)

Were you referred for ABA by someone?

☐ Yes ☐ No If yes, who:

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What do you want ABA to help with?

Please describe any behavior issues your child has (e.g., self-injurious, aggressive towards others, etc.) and methods used to decrease behaviors.

Please describe your child's current communication skills (e.g., sign language, PECS, verbal).

What else would you like us to know about your child?

Current & Previous Services

Current School/Placement (Type of Special Educational Services)

Name of School:	**Years attended:**
Does your child receive school services? ☐**IEP** ☐**504**	**Hours in school p/wk:**

Behavioral Consultation Provider

If your child receives or has received behavioral services, please complete below:
Dates of service: **to** **Frequency of service:** **per**
Agency Name: **Provider Name:**
Provider Phone:
Please describe services:
Please describe the results in achieving goals:

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If additional behavioral provider, please complete below:			
Dates of service:	**to**	**Frequency of service:**	**per**
Agency Name:		**Provider Name:**	
Provider Phone:			
Please describe services:			
Please describe the results in achieving goals:			

Additional Diagnostic Information

If your child has other diagnoses, please list below:

Supportive Services

Please list other services your child <u>currently</u> receives both in school and out of school. Please enclose a copy of the child's most recent IEP or IFSP and goals from each area checked.

Service/Therapy:	Location:	Minutes/Week:
☐ Early Intervention Services Provider:	☐ School ☐ Home	
☐ Speech and/or language therapy Provider:	☐ School ☐ Home	
☐ Occupational Therapy Provider:	☐ School ☐ Home	
☐ Physical Therapy Provider:	☐ School ☐ Home	
☐ Vision services Provider:	☐ School ☐ Home	
☐ Hearing services Provider:	☐ School ☐ Home	
☐ Psychotherapy/Counseling Provider:	☐ School ☐ Home	
☐ Other Provider:	☐ School ☐ Home	

Additional Information

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Often there are shorter, mini sessions, available to families that are on the wait list. Would you be interested in any of the following:

- ☐ Family Guidance (short sessions focused on parent skills)
- ☐ Intensive behavior intervention (mini session to address significantly challenging behaviors)
- ☐ Other supports for families that are available

WA State requires that we ask the following questions:

Do you/or the family currently have any legal involvement that would impact your child's care? Example: parenting plan	
☐ **Yes** ☐ **No**	**If yes, please explain below:**

Has the client ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations?	
☐ **Yes** ☐ **No**	**If yes, please explain below & include discharge documentation:**

Does the client have a history of substance use, including tobacco use?	
☐ **Yes** ☐ **No**	**If yes, please explain below:**

Does the client have a history of problem or pathological gambling or computer gaming?	
☐ **Yes** ☐ **No**	**If yes, please explain below:**

Is the client an identified risk to themselves or others, to include self-injurious behaviors? Are they suicidal or do they pose a risk of homicide?	
☐ **Yes** ☐ **No**	**If yes, please explain below:**

Is the client under department of corrections supervision?	
☐ **Yes** ☐ **No**	**If yes, please explain below:**

Is the client under civil or criminal court ordered mental health or substance use disorder treatment?	
☐ **Yes** ☐ **No**	**If yes, please explain below:**

Is there a court order exempting the individual participant from reporting requirements?	
☐ **Yes** ☐ **No**	**If yes, please provide a copy of the court order.**

ADMIN ONLY
Review of this form per WAC 246-341-0610(1)(c) requirements
Name, Credentials **Acceptance Date**

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