Behavior Analysts of West Michigan

Application for Services Checklist

This form is not required, but rather is meant to help families gather all required information and documentation required to start ABA services at Behavior Analysts of West Michigan (BAWMI).

- ☐ Completed in-take packet
  - Client intake questionnaire
  - Signed Consent form
  - Emergency Information form
  - Information Exchange Authorizations (*optional*)
  - Photo and Video Release forms (*optional*)
- ☐ Provide copies of the following forms:
  - Report/evaluation confirming diagnosis of Autism Spectrum Disorder (ASD)
  - Most recent physical examination (must be completed by PCP within the past 12 months)

    ** If you object to a physical examination, please submit a signed statement that the child is in good health and the parent/guardian assumes responsibility for the child's state of health while at BAWMI*
  - Any other recent evaluations the child has had completed (i.e. school, speech, OT, neurological, etc…)
  - An up-to-date record of all immunizations the child has had
- ☐ If insurance is involved, pre-authorization is required prior to any evaluation, therapy, or any other service being provided
- ☐ In-take interview
- ☐ VB-MAPP completed by BAWMI staff
- ☐ Meeting with BCBA to discuss goals and program plan
- ☐ Arrangement of therapy schedule

Should you have any questions regarding the application process,
please contact us by phone at 616-915-2066, or email at wmichiganba@gmail.com.

Behavior Analysts of West Michigan

Application for Services

The following is required so that we can best meet the physical, intellectual, behavioral, and emotional needs of your child and family. The information provided will remain confidential in accordance with HIPPA laws.

Personal Information

Child's Name: _____ DOB: _____

Address: _____

Parent/Guardian: _____ Phone: _____

Email: _____ @ _____

Parent/Guardian: _____ Phone: _____

Email: _____ @ _____

Where did your child receive a **medical diagnosis** of Autism Spectrum Disorders?

_____

Date of evaluation: _____ Name of evaluator: _____

Insurance Information

Primary Insurance Company: _____

Carrier: _____ DOB: _____ Relation: _____

Occupation: _____ Employer: _____

Group #: _____ Enrollee ID: _____

Secondary Insurance Company: _____

Carrier: _____ DOB: _____ Relation: _____

Occupation: _____ Employer: _____

Group #: _____ Enrollee ID: _____

Educational Information

If your child is not currently in school, skip to the next section

Name of School: _____ Grade: _____

Classroom Description (*circle one*): Self-contained Resource room Other

Most Recent IEP/IFSP Date: _____

Additional Services

Please list any services your child currently receives (i.e. speech, OT, etc…):

Type of Service	Provider Name	Duration of Services	Frequency

Family Information

Members of household (please list name, age, & relationship to client):

_____

_____

_____

Please indicate if any of the following variables that could affect your child's treatment apply to your family (historically or currently). If yes, include a brief explanation.

Condition	Yes	No	Description
Medical conditions (i.e. epilepsy, diabetes, etc)			
Behavioral health conditions (i.e. depression, ADHD, etc)			
Legal issues that would affect treatment (i.e. persons child is allowed to leave with, etc)			
Spiritual/cultural values that would affect treatment (i.e. dietary, medical treatment, religious holidays, etc)			

Medical & Behavioral Health History

How has your child's overall health been?

_____

_____

Has your child exhibited any sexualized behavior (i.e. removing clothes in public, touching others inappropriately, etc)? If so, please describe on the lines below.

_____

_____

Please list your child's current medications (both prescription and over-the-counter) **and** the conditions being treated:

_____

_____

Please describe your child's **food and medication allergies**, if any:

_____

_____

Do you have any concerns regarding your child's development (i.e. speech/language, motor movements, eating/feeding problems, etc)?

_____

_____

_____

What interests or excites your child, what are his strengths? What frustrates her?

_____

_____

_____

What other information would you like us to know?

_____

_____

_____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone (home): _____ **Phone (cell):** _____

Relationship to client: _____

Name: _____

Phone (home): _____ **Phone (cell):** _____

Relationship to client: _____

Behavior Analysts of West Michigan

Parent Questionnaire

Using a rating scale of 1-5 (5 being very important to you, 1 being the least important to you), rate the following areas of learning you want for your child.

1. Communication (using signs/pictures/speech to get wants and needs met.)

   5 4 3 2 1
   most important least important

2. Social Skills (approach others, say hi to others, sharing experiences with others)

   5 4 3 2 1
   most important least important

3. Play Skills (plays appropriately with toys, plays with a variety of toys)

   5 4 3 2 1
   most important least important

4. Behavior (decrease screaming, crying, hitting, kicking, biting, etc)

   5 4 3 2 1
   most important least important

5. Behavior (decrease unusual behaviors like tapping items, spinning toys, licking things, etc)

   5 4 3 2 1
   most important least important

6. Personal care (dress and undress self, brush teeth, wash hands, etc)

   5 4 3 2 1
   most important least important

7. Toileting (be independent and self-initiating using the toilet for urinating and bm's)

   5 4 3 2 1
   most important least important

8. Eating (eat with utensils, eat a variety of foods, drink from a cup)

   5 4 3 2 1
   most important least important

Behavior Analysts of West Michigan

Consent for Treatment

Client name: _____ **Birthdate:** _____

Legal Guardian: _____

- ✓ My consent for treatment/assessment of my child/myself, listed above is **voluntary**.
- ✓ I understand that no guarantees have been made to me about the results of this treatment/assessment; I understand the plan for this treatment/assessment and also understand the potential **risks and benefits**.
- ✓ I understand that it is **my responsibility** to inform my child's therapist, if there are any significant changes in my child's physical or emotional condition.
- ✓ I understand that I have the right to terminate treatment/assessment with my child's therapist at any time I choose.
- ✓ I understand that if my child/I state or suggest that he/she is, or I am, abusing or have recently abused a child or vulnerable (incompetent, mentally disable or otherwise restricted) adult, or a child or vulnerable adult is in danger of abuse, professionals at Behavior Analysts of West Michigan, as health care professionals are, by law, **required to report** this information to the appropriate social services and/or legal authorities
- ✓ I understand that if my child or I disclose intentions or a plan to harm another person and has/have the ability to carry out that plan, professionals at Behavior Analysts of West Michigan have a duty to warn the intended victim and report this information to legal authorities. If my child/I clearly indicate(s) plans to harm himself/herself/myself, professionals at Behavior Analysts of West Michigan are required to notify appropriate authorities or family members.
- ✓ For the purpose of payment for services, I give professionals at Behavior Analysts of West Michigan **permission to disclose my information to any provider, organization, and/or insurance carrier** that may be responsible under a contract for payment of incurred charges. Because some insurance companies or their representatives require reviews to assess the quality of the services for which they pay, I authorize professionals at Behavior Analysts of West Michigan to release or share only that information which is necessary to complete the reviews, which could include information about my child's care, communicable diseases, and other medical information. The undersigned authorizes professionals at Behavior Analysts of West Michigan to release information contained in my child's medical records to insurance company(s), Medicaid, Medicare, or other third-party payers or their authorized representatives.

Regarding payment for service:

- I understand that I, the undersigned, am responsible for payment of all charges due and owing to Behavior Analysts of West Michigan. I assign benefits payable directly to Behavior Analysts of West Michigan.
- I authorize Behavior Analysts of West Michigan and their billing service to directly bill any third-party payer which may provide coverage to my child, and request that any payments are made directly to Behavior Analysts of West Michigan. The undersigned assigns to Behavior Analysts

of West Michigan all rights to benefits, insurance proceeds, settlement payments or judgments to which my child may be entitled for the services rendered by professionals employed by Behavior Analysts of West Michigan during the entire continuum of care rendered.

- I understand that I may review charges to my account at any time and that I may be charged up to the full rate if proper 24-hour notice is not given for broken appointments. I hereby acknowledge that I have received information regarding issues related to broken appointments.
- I understand that if I do not assure payment in a timely manner, my outstanding bill may be turned over to a collection agency or legal counsel for collections.
- I understand that this Consent contains all the terms of the agreement between the parties with respect to its subject matter and may be emended only in writing by both parties. This Consent shall be binding upon the parties hereto, their heirs, executors, administrators or authorized representatives Behavior Analysts of West Michigan.

Additionally:

- I understand that some portion of my child's evaluation and/or intervention services is being conducted by an ABA tutor. This means that they will be supervised by a Board Certified Behavior Analyst in this practice and will need to disclose information related to my child's treatment. All of this information (except that described previously under disclosure provisions) will remain confidential within the practice. With some insurance, the supervising BCBA may be indicated on your explanation of benefits as the therapist of record.
- I am aware of and understand the ***inclement weather policy*** of Behavior Analysts of West Michigan: as a general rule, all ABA services are cancelled when Grand Rapids Public Schools are closed due to weather related conditions.

I understand that by signing below, I am indicating that I have the authority (e.g. Legal guardianship, Full or Partial legal custody) to provide consent for the child who will be the client with Behavior Analysts of West Michigan:

Client/Parent/Legal Guardian Signature	Date
Guarantor Signature	Date
Witness Signature	Date

March, 2013

Behavior Analysts of West Michigan

Photo Permission Release

Behavior Analysts of West Michigan may photograph your child on occasion to use in the room for therapeutic purposes or the photographs may be used on our website for advertising purposes. The following release states that you will allow your child to be photographed for therapy and website use.

I, _____, give permission to Behavior Analysts of West Michigan to photograph my child for learning purposes. In addition, I understand that these photos may be used on the Behavior Analysts of West Michigan website.

By signing below, I agree to the photographing of my child.

_____ _____

Parent/Guardian Signature Date

Behavior Analysts of West Michigan

Video Permission Release

Behavior Analysts of West Michigan use videotaping as part of our therapy services. These videos are used to keep record of skills learned, fidelity checks of staff presentation of therapy, and video modeling to teach skills. These videos may also be used in training new staff and for professional presentations. The following release states that you will allow your child to be videotaped for therapeutic purposes, as well as, professional training.

I, _____, give permission to Behavior Analysts of West Michigan to video my child for learning purposes. In addition, I understand that these videos may be used for training new staff and for professional presentations.

By signing below, I agree to the videotaping of my child.

_____ _____

Parent/Guardian Signature Date