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
  - Application for Services
  - Caregiver Questionnaire
  - 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. speech, OT, neurological, etc…)
  - A copy of the child's most recent IEP, if applicable
  - 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.*

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# 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:** _____

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## Caregiver Questionnaire

Using a rating scale of 1-5 (where 5 is most important and 1 is least important), please indicate which of the following areas you'd like to see addressed with your child:

1. **Communication** (i.e. uses signs/pictures/speech to get wants and needs met, etc.)

   5 4 3 2 1
   most important least important

2. **Social skills** (i.e. approaches others, greets others, shares experiences with others, etc.)

   5 4 3 2 1
   most important least important

3. **Play skills** (i.e. plays appropriately with toys, plays with a variety of toys)

   5 4 3 2 1
   most important least important

4. **Inappropriate behavior**s (i.e. screaming, crying, hitting, kicking, biting, etc.)

   5 4 3 2 1
   most important least important

5. **Self-stimulatory behaviors** (i.e. repetitive or stereotypical such as tapping, spinning, etc.)

   5 4 3 2 1
   most important least important

6. **Personal care** (i.e. dresses and undresses self, brushes teeth, washes hands, etc.)

   5 4 3 2 1
   most important least important

7. **Toileting** (i.e. initiates and independently uses the toilet for urinating and BMs)

   5 4 3 2 1
   most important least important

8. **Eating** (i.e. eats with utensils, eats a variety of foods, drinks from a cup, etc.)

   5 4 3 2 1
   most important least important

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**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

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## 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