



BEHAVIOR SERVICES

OF THE ROCKIES

Intake Assessment

SECTION 1: DEMOGRAPHIC INFORMATION

Participant's Name:				Date of Referral	/	/
Address:			Home Phone:		-	-
City:			State:		Zip:	
DOB:		Age:		Diagnosis:		
FOR PRIVATE INSURANCE: Sponsor's SSN:			-		-	
Parent/Caregiver Name:				Cell Phone:	-	-
Email Address:				Work Phone:	-	-
Case Mgr/Resource coord.				Phone:		
Living Arrangement:		<input type="checkbox"/> Family	<input type="checkbox"/> Staffed Site			

FOR OFFICE USE ONLY

First Contact with Parent/Caregiver:

Date: _____ Time: _____ Init: ____ Notes: _____

Intake Assessment Completed:

Date: _____ Time: _____ Init: ____ Notes: _____

First Appointment Scheduled:

Date: _____ Time: _____ Init: ____ Notes: _____

Attempts to Contact:

1. Date: _____ Time: _____ Init: ____ Notes: _____

2. Date: _____ Time: _____ Init: ____ Notes: _____

3. Date: _____ Time: _____ Init: ____ Notes: _____

4. If unable to contact in three attempts, Resource Coordinator notified:

Date: _____ Time: _____ Init: ____ Notes: _____

If determined that our services do not meet parent / caregivers needs, refer to:

Local CCB, or Autism Society

Notes:

SECTION 2: FUNDING

Please list any funding sources you currently have.

1. MEDICAID WAIVER (CES/SLS/HCBS-CHILD/HCBS-ADULT/TBI, CWA, CHRP) AND/OR OTHER AVAILABLE FEDERAL FUNDING SOURCES:

Medicaid number:

Diagnosis Code:

2. TRICARE ECHO

Case Manager

Name:

Phone: - -

DIAGNOSIS CODE (must have before service begin for TRICARE):

Referring Physician for ABA or who made the diagnosis:

3. PRIVATE INSURANCE

Provider:

Policy number:

Provide photocopy of insurance card (front/back):

Yes

Will provide

4. PRIVATE PAY

RATE SHEET PROVIDED

SERVICE AGREEMENT PROVIDED

5. OTHER:

SECTION 3: SERVICES

Check the service the parent / caregiver is interested in.

- Type I: Applied Behavior Analysis (ABA) In Clinic
- Type II: Applied Behavior Analysis (ABA) In Home/Community Supports
- Type III: Comprehensive Behavioral Intervention Services (CBIS)
- Type IIIa: (ICT) Intensive Collaborative Teaching
- Type IIIb: (PREP) Pause-Reset-Educate-Practice
- Type IIIc: (BFIT) Behavioral Fitness Center
- Type IV: Other:

SECTION 4: PARTICIPANT INFORMATION

1. Current Treatment(s): (list or N/A)
2. Current Medication(s): (list or N/A)
3. Previous Treatment(s): (list or N/A)
4. Previous Medications: (list or N/A)
5. Current School, Day Habilitation, and/or Vocational Program: (list or N/A)
6. Times and days that are good for the parent/caregiver and/or the participant for scheduling (Please check the box when there is availability):

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AFTERNOON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EVENING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. List Participant's current likes/interests:

8. Reason for referral:

Check if observed by the parent, school, facility, etc.

- | | | |
|--|--|--|
| <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Property Destruction | <input type="checkbox"/> Verbal Disruption |
| <input type="checkbox"/> Non-cooperation | <input type="checkbox"/> Self-stimulation | <input type="checkbox"/> Self – Injury |
| <input type="checkbox"/> Toileting Problems | <input type="checkbox"/> Bizarre Speech | <input type="checkbox"/> Pica |
| <input type="checkbox"/> Feeding Problems | <input type="checkbox"/> Inappropriate Social Behavior | <input type="checkbox"/> Elopement |
| <input type="checkbox"/> Other: _____ | | |

List & Describe:

Of the behaviors checked above, list the top three of concern to the parent/caregiver:

1.

List # of times behavior occurs: Hourly | Daily | Weekly | Monthly

2.

List # of times behavior occurs: Hourly | Daily | Weekly | Monthly

3.

List # of times behavior occurs: Hourly | Daily | Weekly | Monthly