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**Intake Assessment**

**SECTION 1: Demographic Information**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant’s Name: | | | | | | Date of Referral: | | | | |
| Service Address: | | | | County: | | | | | | |
| City: | | | | | State: | | | | | Zip: |
| Participant DOB: | Age: | | Diagnosis: | | | | | | Proof of Dx recvd : | |
| Treating Physician (PCP): | | Physician phone: | | | | | | Date of Dx: | | |
| (Private insurance only) Sponsor’s SSN:      -     - | | | | | | | Sponsor DOB: | | | |
| Parent/Caregiver name: | | | | | | Cell Phone:      -     - | | | | |
| Email Address: | | | | | | Phone:      -     - | | | | |
| Living Arrangement:  Family  Staffed Site  Other: | | | | | | | | | | |
| Service coordinator | | | | | | Phone:      -     - | | | | |
| Email Address: | | | | | | Work Phone:      -     - | | | | |

**SECTION 2: FUNDING (office use only):**

*Please list any funding sources you currently have:*

1. Medicaid waiver ( <Select one> SLS HCBS-DD TBI HIGH NEED EPSDT EI MAD-NM)

Medicaid #:       Diagnosis Code/s:

Provide copy of Medicaid card (front and back)

2. Tricare

Case Manager:       Case Manager Phone:      -     -

DX Code (required):

For Tricare: Copy of IEP received?  Yes  No, Will provide

3. other private Insurance

Insurance Company:       Policy Holder Name:

Policy Number:       Policy Holder DOB

Member ID Number       DX code/s

Photocopy of Insurance Card (front and back)  Yes  No, will provide

5. Private Pay (Submit signed patient responsibility agreement)

6. Other:

**SECTION 3: SERVICES**

*Check the service/s needed or interested in.*

Type I: Applied Behavior Analysis (ABA) Brief Consultation

Type II: Applied Behavior Analysis (ABA) in-home/Community Supports

Type III: Training (Staff training, ABA Parent training, Crisis training: Professional Crisis Management)

Type IV: Auxiliary Aids and Supports (translator services needed, sign language, etc.)

Type V: Other:

**SECTION 4: PARTICIPANT INFORMATION**

*Please indicate any other services received in all other settings:*

1. Current Treatment(s): (list or N/A)

2. Previous Treatment(s): (list or N/A)

3. Current Medication(s): (list or N/A)

4. Previous Medications: (list or N/A)

5. List Participant’s current likes/interests:

6. Possible Behavioral Concerns:

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

Physical Aggression  Property Disruption  Verbal Disruption

Non-cooperation  Self-stimulation  Self – Injury

Toileting Problems  Bizarre Speech  Pica

Feeding Problems  Inappropriate Social Behavior  Elopement

Other:

List & Describe:

Of the behaviors selected 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

Any Medical concerns:

Once we determine eligibility for services, we will contact you to discuss staff availability, our service model and ensure we will be the best fit for services to begin the process of obtaining an authorization and begin services. We provide most of our services in the community for the convenience of the individuals we serve. This may mean our clinician availability cannot always meet our individual’s availability. We will work with you to get you services that are as convenient as possible, without the hassle of a wait list or scheduling with a clinic. Thank you in advance for your patience and flexibility.

Hours of Availability:

Please mark the times you and the client ARE available for services.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| 8:00 am |  |  |  |  |  |  |
| 9:00 am |  |  |  |  |  |  |
| 10:00 am |  |  |  |  |  |  |
| 11:00 am |  |  |  |  |  |  |
| 12:00 pm |  |  |  |  |  |  |
| 1:00 pm |  |  |  |  |  |  |
| 2:00 pm |  |  |  |  |  |  |
| 3:00 pm |  |  |  |  |  |  |
| 4:00 pm |  |  |  |  |  |  |
| 5:00 pm |  |  |  |  |  |  |
| 6:00 pm |  |  |  |  |  |  |

Cultural Considerations:

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.

How would you like us to refer to the participant?

Communication preferences:

I do not have a preference, BSOTR may contact me using either email or phone  Yes  No

If yes, please indicate below best contact number(s):

Home Number:       Best time(s) to call:

Is it ok to leave a message at this number?  Yes  No

Cell Number:       Best time(s) to call:

Is it ok to leave a message at this number?  Yes  No

Is it ok to send text messages to this number?  Yes  No