Dear Caregiver:

Thank you for your interest in the Familylinks ABA Clinic. We know you have many options to choose from and appreciate you having selected us to provide you with ABA services. Please complete the attached intake forms and return them to Familylinks Autism Services along with the following documents in order to initiate services.

- Written Order for IBHS (if you do not have a written order for services, please call Autism Services 412-924-0246 to schedule an assessment for IBHS ABA services. You can also contact your child's pediatrician or diagnostic prescriber for a written order).
- Updated Neuropsychological or Diagnostic Evaluation
- Current IEP, IFSP, or 504 plan (if applicable)
- Copy of insurance cards (front and back)
- Relevant medical information, including current medication list

All forms and documents can be returned by the following methods:

Email: AutismServices@familylinks.org

Mail: Familylinks, C/O: Autism Services, 2644 Banksville Road, Pittsburgh, PA 15216

Fax: 412-291-9980

We look forward to working with you and your family.

Sincerely,

The Familylinks ABA Team

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ABA Services Intake Form

Please complete this form with as much detailed information as possible. The more information we have, the better we can serve you and your child.

Demographic Information

Child's Name:_____
DOB:_____
Sex at birth: ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer
Which one of the following best describes your child?
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Hispanic or Latino ☐ Multiracial or Biracial
☐ Other
Social Security Number (for insurance purposes):
_____
Name of Parents or
Guardians:_____
Phone Number: (cell)_____
(other):_____
Address:_____
_____
_____
Email addresses (list all who should be involved in communications about participant):
_____
_____

Insurance

Primary Insurance:_____
Policy Holder: _____DOB:_____
ID#:_____ Group #:_____
Medicaid ID#_____
Secondary Insurance:_____
Policy Holder: _____DOB:_____
ID#:_____ Group #:_____
Medicaid ID#_____

We will need a copy of all insurance cards (front and back)

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Written Order for IBHS Services:

Have you received prior IBHS Services? ☐ Yes ☐ No

If yes, please list prior agency:

_____

Medical and Treatment Background

Name and phone number of child's pediatrician practice:

_____

Name of the specific doctor you see:

_____

Child's height, weight and BMI: _____

Child Allergies: _____

Medications? List all current meds including dosages and the prescriber:

_____

_____

Any additional health issues we should be aware of: _____

_____

May we contact your child's doctor for more information about your child in order to develop an informed treatment plan? ☐ Yes ☐ No *You can revoke this consent at any time*

Does your child see any other service providers? ☐ Yes ☐ No

If yes, list below:

Type of Service:_____

Name of Provider:_____

Frequency of Service:_____ May we contact? ☐ Yes ☐ No

You may revoke this consent at any time

Please provide any relevant treatment plans from other service providers

Educational Background

Does the child attend school? ☐ Yes ☐ No
If yes:
Name of school: _____ Grade Level: _____
Contact number: _____
May we contact the school for more information about your child in order to develop an informed treatment plan? ☐ Yes ☐ No
You may revoke this consent at any time.

Please provide any Individual Family Support Plans or Individual Education Plans you have or have received in the past.

Family Information

Who lives in the house with the child? List all family members and any pets:_____
_____
_____

What language(s) or other forms of communication are used in the home?:_____

Please tell us about any traditions, rituals, or celebrations your family participate in:
_____
_____
_____
_____
_____

ABA Services:

Our clinic runs both individual and group sessions, with emphasis on group sessions and peer interactions. Session times have limited capacity and are subject to change based on enrollment. Please circle your time preferences and we will do our best to accommodate your requests.

Group Sessions currently run:
Tuesday evening from 4-6 and Saturday morning from 9-12
*Group sessions will expand as the number of clients enrolled increases

Individual Sessions are available Monday through Friday:

Morning Sessions	Afternoon Sessions	Evening Sessions
8:00 am – 11:00 am 8:30 am – 11:30 am 9:00 am – 12:00 pm	12:00 pm – 3:00 pm 12:30 pm – 3:30 pm	4:00 pm – 7:00pm*

Extra Information About Your Child

Play and Leisure

Does your child explore toys or play items in his/her/their environment?
☐ Yes ☐ No ☐ Not Sure

Does your child independently play with toys as they are designed? ☐ Yes ☐ No ☐ Not Sure

Does your child play with a variety of toys or engage in a variety of leisure activities?
☐ Yes ☐ No ☐ Not Sure

Does your child engage with peers in play? ☐ Yes ☐ No ☐ Not Sure

Does your child show interest in the behaviors of others? ☐ Yes ☐ No ☐ Not Sure

Other helpful information:
_____
_____
_____
_____

Group Instruction

Does your child sit appropriately in a group of 2 to 3 peers? ☐ Yes ☐ No ☐ Not Sure

Does your child follow group instructions? ☐ Yes ☐ No ☐ Not Sure

Does your child raises hand to ask or answer a question? ☐ Yes ☐ No ☐ Not Sure

Other helpful information:
_____
_____
_____
_____

Daily Living Skills

Does your child transition to and from activities appropriately? ☐ Yes ☐ No ☐ Not Sure

Does your child wait during transitions when asked? ☐ Yes ☐ No ☐ Not Sure

Does your child wear diapers? ☐ Yes ☐ No

Does your child need help in the bathroom? ☐ Yes ☐ No
If yes, please describe:
_____
_____
_____

Please describe your child's daily routine. Please consider eating times, naps (if applicable), and any other scheduled activities.
_____
_____
_____
_____
_____
_____

Behavior

Does your child engage in any behaviors of concern? For example, hit self or others, screaming, drops to the floor, etc. ☐ Yes ☐ No ☐ Not Sure

If yes, please describe:

_____
_____
_____
_____
_____

Your Child Interests

My child likes:

_____
_____
_____
_____
_____
_____

My child dislikes:

_____
_____
_____
_____
_____
_____
_____

Additional Information

Please describe what skills you hope your child gain and/or what behaviors you hope to change through therapy:

_____
_____
_____
_____

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_____

_____

Consent to Collaborate

I, _____, give permission for Familylinks Autism Services to collaborate on (child's name) _____ behalf with the following:

☐ School: _____

☐ Doctor: _____

☐ Speech Therapist: _____

☐ OT: _____

☐ PT: _____

☐ Counselor: _____

☐ Other: _____

Signature:

_____

Date: _____

Printed Name:

_____

Client Name:

_____

Emergency Contacts

Please list at least two emergency contacts for your child. Please list any persons besides yourself who may pick-up your participant from ABA services. *Whoever picks up must show photo identification* to a staff member before we will release a participant to their care. *You can revoke this consent at any time*

Child's Name:_____

Name of Emergency Contact: _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____
Permission to pick up and drop off? **Y** **N**

Name of Emergency Contact; _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____
Permission to pick up and drop off? **Y** **N**

Name of Emergency Contact: _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____
Permission to pick up and drop off? **Y** **N**

Signature:

_____

Date: _____

Printed Name:

_____

Client Name:

_____

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Video and Photo Release Form

I give consent for my child, _____, to have their photo or video taken for INTERNAL uses. **It is mandatory we have at least a photo on file of every child.** Video usage is for training purposes.

☐ **I** consent to internal use of (circle): Videos Photos

☐ **I do not** consent to internal use (circle): Videos Photos

I give consent for my child to have their photo or video taken for EXTERNAL uses such as marketing materials, etc.

☐ **I** consent to external use Videos Photos

☐ **I do not** consent to external use Videos Photos

Signature of parent or guardian:

_____

Printed Name:

_____

Date: _____

Client Name:

_____

First Aid Consent

I give consent for my child, _____, to receive first-aid services when in the care of ABA staff.

Please list any allergies or medications that would impact the use of First-Aid:

_____

_____

_____

I understand I will receive a written incident report should my child receive any first-aid when in the ABA clinic or in the care of ABA staff.

Signature of parent or guardian:

_____

Date: _____

Printed Name:

_____

Client Name:

_____

Checklist of Items

Please use this checklist to ensure you have all necessary items signed and completed.

☐ Completed all pages of Intake Packet

☐ Have included a copy of an IEP, 504, or IFSP, if applicable

☐ Have included a copy of your child's Neuropsychological evaluation or diagnostic evaluation

☐ Copy of the Written Order for IBHS services

☐ Copy of your child's insurance card (front and back)

Thank you for completing this form! Please return to:

Familylinks
C/O: Autism Services
2644 Banksville Road
Pittsburgh, PA 15216

Or:
AutismServices@familylinks.org
Fax: 412-201-9980