Dear Caregiver:

Thank you for your interest in Familylinks Autism Services. We know you have many options to choose from and appreciate you having selected us to assist you with this important process.

Please complete the attached intake forms to provide Familylinks Autism Services with information to identify how we can best support you. Once you complete the intake forms, they will need to be returned to Familylinks Autism services 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. They will need the information below to schedule you).
- Updated Neuropsychological or Diagnostic Evaluation
- Current IEP, IFSP, or 504 plan (if applicable)
- Copy of insurance cards (front and back)
- Relevant medical information

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

Thank you again for your interest in Familylinks services. We look forward to working with you and your family.

Sincerely,

Dr. Rachel Schwartz, PhD, BCBA-D
Director of Autism Services and Clinical Integration

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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
Social Security Number:
_____
Name of Parents or
Guardians:_____
Phone Number: (cell)_____
(other):_____
Address:_____
_____
_____
Email addresses (list all who should be involved in communications about participant):
_____
_____

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

Insurance

Referring Physician:_____
Office Contact Number: _____
Primary Insurance:_____
Employer:_____
Policy Holder: _____DOB:_____
ID#:_____ Group #:_____
Medicaid ID#_____
Secondary Insurance:_____

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

Written Order for IBHS Services:

Please select ABA service on Written Order: ☐ Individual ☐ Group
Setting: ☐ School ☐ Home ☐ Community ☐ Clinic
Hours prescribed: _____
☐ Per Week ☐ Per Month
Have you received prior IBHS Services? ☐ Yes ☐ No
If yes, please list prior agency:
_____

Medical and Educational Background

Name of child's pediatrician practice:
_____
Name of the specific doctor you see:
_____
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

Does the child attend school? ☐ Yes ☐ No
If yes, list name of
school:_____
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.

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Family Information

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

What language(s) is spoken in the home?:_____

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

ABA Services:

Our Clinic Group Services run the following times. Please circle your time preference.

Monday-Friday 9-12pm 12:30-3:30pm 4-7pm

Weekends By appointment

Some individuals may have individual services. Please mark availability for these services.

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
8:00 to 9:00 AM						
9:00 to 12:00 PM						
12:30 PM to 3:30 PM						
4:00 PM to 7:00 PM						

Family Training is an opportunity for a behavior analyst or specialist to meet with families without the child present. This training focuses on teaching parents skills and techniques when engaging with their child. Please complete the following schedule blocks for when a caregiver or family would be available.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:30 to 9:00 AM						
9:00 to 12:00 PM						
12:00PM to 3:00 PM						
3:00 PM to 6:00 PM						
6:00 to 7:00PM						

Presentation of Information

Does your child follow verbal routines or schedules? ☐ Yes ☐ No ☐ Not Sure
Does your child follow visual routines or schedules? ☐ Yes ☐ No ☐ Not Sure

If Yes, does your child prefer:
☐ Written ☐ Photo ☐ Object ☐ Not Sure

How much at once?
☐ One at a time ☐ First/ Then ☐ Three to four activities at a time ☐ All Activities
☐ Not Sure
Other:_____
_____
_____
_____
_____

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Communication

Receptive (*how does your child receive information?)*	Expressive (*how does your child communicate information?)*
☐ Sentences ☐ Short Phrases ☐ One Word ☐ American Sign Language ☐ Gestures ☐ Reads Sentences ☐ Reads 2-3 Words ☐ Reads Single Words ☐ Pictures ☐ Objects	☐ Sentences ☐ Short Phrases ☐ One Word ☐ American Sign Language ☐ Gestures ☐ Pictures ☐ Sounds
Additional Information: _____ _____ _____	

Receptive Skills

Does your child respond to his/her/their name? ☐ Yes ☐ No ☐ Not Sure

Does your child follow directions to select an object (pick up, put down, touch, etc)?
☐ Yes ☐ No ☐ Not Sure

Does your child follow instructions during a routine situation? ☐ Yes ☐ No ☐ Not Sure

Does your child make a choice between at least two items that are present?
☐ Yes ☐ No ☐ Not Sure

Does your child make a choice between at least two items that are NOT present?
☐ Yes ☐ No ☐ Not Sure

When asked, will your child select all similar items from a group? For example, will your child select all the blue blocks from a set of colored blocks? ☐ Yes ☐ No ☐ Not Sure

Does your child imitate sounds? ☐ Yes ☐ No ☐ Not Sure

Does your child imitate movements (example: clap hands, wave, etc)?
☐ Yes ☐ No ☐ Not Sure

Other helpful information:

_____
_____
_____
_____
_____

Expressive

Does your child make requests? ☐ Yes ☐ No ☐ Not Sure
How?

_____
_____

Will your child respond to the question "What do you want?"?
☐ Yes ☐ No ☐ Not Sure ☐
Other:_____
_____

Will your child request something that is not present in the environment?
☐ Yes ☐ No ☐ Not Sure
Will your child ask "Wh" questions (*who, what, where, when)*? ☐ Yes ☐ No ☐ Not Sure

Will your child respond to "Wh" questions? ☐ Yes ☐ No ☐ Not Sure

Does your child know the names of common objects in your house or community?
☐ Yes ☐ No ☐ Not Sure

Does your child sing along with songs?
☐ Yes ☐ No ☐ Not Sure

Other helpful information:

_____
_____
_____
_____
_____

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:
_____
_____
_____
_____

Routines

Does your child follow daily routines at home? ☐ Yes ☐ No ☐ Not Sure

If yes, independently or with support? ☐ Independently ☐ With Support ☐ Not Sure

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.
_____
_____
_____
_____
_____
_____

Other helpful information:
_____
_____
_____
_____
_____

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

Does your child ask for help?	☐ Yes ☐ No ☐ Not Sure
Is your child upset by changes in routine?	☐ Yes ☐ No ☐ Not Sure
Does your child advocate for his/her/their needs?	☐ Yes ☐ No ☐ Not Sure

Do you use transitional cues or warning cues when something is about to change?	☐ Yes ☐ No ☐ Not Sure
Does your child try things on his/her/their own or wait for you?	☐ Yes ☐ No ☐ Not Sure
Does your child have a particular fear?	☐ Yes ☐ No ☐ Not Sure
Does your child have a particular fascination?	☐ Yes ☐ No ☐ Not Sure
Does your child seem bothered by specific sounds?	☐ Yes ☐ No ☐ Not Sure
Does your child seem bothered by specific textures?	☐ Yes ☐ No ☐ Not Sure
Please list anything else that may help us better serve you and your child (add additional pages as needed) _____ _____ _____ _____ _____	

Additional Information

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

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.

Child's Name:_____

Name of Emergency Contact: _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____

Name of Emergency Contact; _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____

Name of Emergency Contact: _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____

Participant Pick-Up Permission Form

Participant safety is of utmost importance to us. 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.

Child's Name:_____

Name of Individual Picking Up: _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____

Name of Individual Picking Up: _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____

Name of Individual Picking Up: _____
Phone Number: (cell)_____
Address:_____
_____
Relationship to Child: _____

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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:

_____

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