



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



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:

Child's height, weight and BMI: _____

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.



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: _____



Communication

<p>Receptive (<i>how does your child receive information?</i>)</p> <ul style="list-style-type: none"><input type="checkbox"/> Sentences<input type="checkbox"/> Short Phrases<input type="checkbox"/> One Word<input type="checkbox"/> American Sign Language<input type="checkbox"/> Gestures<input type="checkbox"/> Reads Sentences<input type="checkbox"/> Reads 2-3 Words<input type="checkbox"/> Reads Single Words<input type="checkbox"/> Pictures<input type="checkbox"/> Objects	<p>Expressive (<i>how does your child communicate information?</i>)</p> <ul style="list-style-type: none"><input type="checkbox"/> Sentences<input type="checkbox"/> Short Phrases<input type="checkbox"/> One Word<input type="checkbox"/> American Sign Language<input type="checkbox"/> Gestures<input type="checkbox"/> Pictures<input type="checkbox"/> Sounds
<p>Additional Information:</p> <hr/> <hr/> <hr/>	

Receptive Skills

<p>Does your child respond to his/her/their name? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p>Does your child follow directions to select an object (pick up, put down, touch, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p>Does your child follow instructions during a routine situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p>Does your child make a choice between at least two items that are present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p>Does your child make a choice between at least two items that are NOT present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p>Does your child imitate sounds? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p>Does your child imitate movements (example: clap hands, wave, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p>
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Is your child upset by changes in routine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Does your child advocate for his/her/their needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure



Do you use transitional cues or warning cues when something is about to change?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Does your child try things on his/her/their own or wait for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Does your child have a particular fear?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Does your child have a particular fascination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Does your child seem bothered by specific sounds?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Does your child seem bothered by specific textures?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:

Printed Name:

Date: _____

Client Name:



Emergency Contacts

Please list at least two emergency contacts for your child.

<p>Child's Name: _____</p> <p>Name of Emergency Contact: _____</p> <p>Phone Number: (cell) _____</p> <p>Address: _____</p> <p>_____</p> <p>Relationship to Child: _____</p> <p>_____</p> <p>Name of Emergency Contact; _____</p> <p>Phone Number: (cell) _____</p> <p>Address: _____</p> <p>_____</p> <p>Relationship to Child: _____</p> <p>_____</p> <p>Name of Emergency Contact: _____</p> <p>Phone Number: (cell) _____</p> <p>Address: _____</p> <p>_____</p> <p>Relationship to Child: _____</p> <p>_____</p>



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.

<p>Child's Name: _____</p> <p>Name of Individual Picking Up: _____</p> <p>Phone Number: (cell) _____</p> <p>Address: _____</p> <p>Relationship to Child: _____</p> <p>Name of Individual Picking Up: _____</p> <p>Phone Number: (cell) _____</p> <p>Address: _____</p> <p>Relationship to Child: _____</p> <p>Name of Individual Picking Up: _____</p> <p>Phone Number: (cell) _____</p> <p>Address: _____</p> <p>Relationship to Child: _____</p>



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