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Getting to Know You

Please note, these forms do not obligate you or SOS Care to ABA service. It is intended for the exchange of information only.

Today's Date _____

Child Information

Child's Name _____ Date of Birth _____

Age _____ Gender _____

Address _____

City _____ State _____ Zip code _____

Which county are you located? _____

Does your child have a medical diagnosis for Autism? ◯Yes ◯No

Will your child need an interpreter? ◯Yes ◯No

Legal Guardian Information

1. Legal Guardian's Name _____

Relationship to Child _____

Address _____

City _____ State _____ Zip code _____

Phone (Home) _____ (Cell) _____

Email _____

Occupation _____ Work phone _____

2. Legal Guardian's Name _____

Relationship to Child _____

Address _____

City _____ State _____ Zip code _____

Phone (Home) _____ (Cell) _____

Email _____

Occupation _____ Work phone _____

Do both parents maintain parental rights? ◯ Yes ◯ No

Are there custody issues of which we need to be aware? ◯ Yes ◯ No

If yes, please explain

_____

_____

_____

_____

Insurance Information

How did you hear about us? _____

Please indicate your Case Work or EI's contact information

Name _____

Agency Name _____

Phone Number _____

Email _____

Do we have consent to release information to and to acquire information from the case worker / EI?
◯ Yes ◯ No

Does your child have any of the follow funding that covers ABA therapy? Check all that apply.

☐ Babynet

☐ **Medicaid, please note SOS only excepts TEFRA Fee for Service Medicaid & Select Health**

please include Medicaid # _____

☐ Insurance: BCBS, TriCare (other insurances may be approved by a single case agreement)

Please list any insurance policies that your child has insurance through.

Primary Insurance Company _____

Group #_____

Insurance ID# _____

Phone # _____

Name of Insured _____

SSN _____

Is ABA Therapy a covered service? _____

Secondary Insurance Company _____

Group #_____

Insurance ID# _____

Phone # _____

Name of Insured _____

SSN _____

Is ABA Therapy a covered service? _____

Please include a copy of both the front and the back of the insurance card(s). If ABA Therapy is not covered then please include a letter from the insurance company stating that as well.

Has or does your child currently receive ABA services? ◯ Yes ◯ No

If yes, with whom were the services through and how long were services provided?

_____

_____

If yes, why is a transition being considered?

_____

_____

_____

If yes, why was he/she discharged?

_____

_____

_____

School / Other Therapy Information

Does your child currently attend school? ◯ Yes ◯ No

Name of school _____ Teacher _____

Days/hours attending _____ Grade/Placement _____

Teacher's Email address _____

Teacher's Phone number_____

Do we have consent to release information to and to acquire information from the teacher / school?
◯ Yes ◯ No

Has the child ever been suspended from school? ◯ Yes ◯ No
If yes, please explain

_____

_____

_____

_____

Does the child have an IEP? ◯ Yes ◯ No

Does your child attend OT / PT / Speech or any other therapy that could possibly impact the days they would be able to attend ABA therapy? ◯ Yes ◯ No

If yes please list days and times your child has this therapy

_____

_____

_____

_____

_____

Patient and Family legal involvement Information

Does the immediate family have any relevant legal issues pending / is incarcerated? ◯ Yes ◯ No

Does anyone currently living in the family home have a history of violence or any arrests? ◯ Yes ◯ No

Has DSS been invoiced in your family at all for any reason? ◯ Yes ◯ No

If you answered yes to any of the above questions please explain :

_____

_____

_____

_____

Other relevant information you would like us to have

_____

_____

_____

_____

_____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Sponsor

Office Use Only

Date Received _____

Consultant Assigned To _____

Date Assigned _____