Intake Packet 2024

Dear Parents and Guardians,

Thank you for considering ABA therapy services from the **Brent Woodall Foundation for Exceptional Children (BWF).** For us to schedule any services, please complete all pages and provide all documents as noted in the attached checklist. We must receive a fully completed packet prior to scheduling any appointment.

We will schedule your Free Individualized Review and Structured Training **"Family FIRST"** meeting after intake is completed. This is provided at our office/therapeutic center, is scheduled for three hours, and includes a basic skills assessment, individualized parent training and tour. It is mandatory for the child and one parent to be present, and we encourage both parents to attend.

Within five business days of Family FIRST, we will email an evaluation report with a recommendation of services. We will then contact you to discuss the schedule of services and provide insurance benefit verification, if applicable. If insurance requires pre-authorization this may take a few weeks, otherwise services may usually begin as soon as a payment method is confirmed, and the initial deposit received.

For questions or more information please call us at 972-756-9170, or contact the following individuals:

Intake Packet, Family FIRST & Scheduling: Nicki Scott, n.scott@woodallkids.org, 972-756-9170 ext. 1000

Billing & Insurance: Tashar Fluker, t.fluker@woodallkids.org, 469-250-7775 direct

Please provide your completed Intake Packet and all documents by mail, email, fax or in person to:

Brent Woodall Foundation for Exceptional Children
ATTN: Nicki Scott
7801 Mesquite Bend Dr. Suite 105
Irving, Texas 75063

E-mail: n.scott@woodallkids.org
Fax: 214-614-4650

The Brent Woodall Foundation for Exceptional Children
INTAKE TABLE OF CONTENTS AND DOCUMENT CHECKLIST

In order for the application to be processed, please read this entire packet and handbook thoroughly, complete all of the forms and information requested, print legibly and provide copies of all of the documents required. See the checklist at right for items to be returned to the BWF.

INTAKE FORMS AND DOCUMENTS REQUIRED	PAGE	ACTION NEEDED	✓
Intake Information	3	Complete all information on pages 3-7	☐
- General and Contact Information	3		☐
- Child's Behavioral Information	4		☐
- School and Therapy Information	5		☐
- Child History and Information	6		☐
HIPAA Authorization	6	Read, complete all information, sign	☐
Child's Recent Photo (head shot in size 4x6)		Attach a copy	☐
Medical History Documents & Immunization Records		Attach copies	☐
Assessments or Evaluations (e.g. cognitive testing, ABA assessments, speech evaluations, diagnostic reports, occupational therapy evaluations) - *Comprehensive diagnostic assessment with an autism diagnosis (F84.0) is required to use insurance as a method of payment. BWF does not provide medical diagnoses.*		Attach copies - *If you are waiting for an evaluation report, please have the Dr. forward to us.*	☐
Individualized Education Plan, Independent Educational Evaluation, and/or Family Support Plan (if previous/current Special Education Program or ECI Services)		Attach copies	☐
Driver License of the Parent attending Family FIRST		Attach copy	☐
Insurance ID Card(s)- if using as a method of payment		Attach copy of front and back	☐

Please only send copies as original documents will not be returned.

The Brent Woodall Foundation for Exceptional Children
INTAKE FORM
GENERAL AND CONTACT INFORMATION

Please check any particular BWF services you are interested in for your child

☐ *1:1 ABA* ☐ *Social Skills Groups* ☐ *BIP* ☐ *Consultation* ☐ *IEP Consultation*

Child's First Name_____ Last Name_____ Middle_____

Preferred Name_____ Date of Birth_____ Age_____

Gender_____ Child's Social Security Number _____

Phone (home/main)_____ Address_____

City_____ State_____ Zip Code _____

Race/Ethnicity_____ Language(s) spoken by child _____

Referred by_____ Phone # _____

Reason for Referral _____

Diagnosed by_____ Phone # _____

Diagnoses_____ Date of Diagnoses _____

Parent/Guardian Full Name _____

Relationship to Child_____ Employer_____

Address (if different from child) _____

City_____ State_____ Zip Code _____

Phone # - Cell_____ Work_____ Home_____

E-mail_____ Driver's License # and State _____/_____

Parent/Guardian Full Name _____

Relationship to Child_____ Employer_____

Address (if different from child) _____

City_____ State_____ Zip Code _____

Phone # - Cell_____ Work_____ Home_____

E-mail_____ Driver's License # and State_____/_____

Child Resides with ☐ Both Legal Parents ☐ Mother ☐ Father ☐ Guardian

If Guardian, is this the legal guardian? ☐ Yes ☐ No Guardian's Relationship to child _____

Who is the Primary Caretake of the child? _____

Child's Insurance Plan_____ Member ID# _____

Subscriber's Name_____ Subscriber's DOB _____

Employer/Group Plan Name_____ Group # _____

Provider Service Phone #_____ Is the child enrolled in any other plan? ☐ Yes ☐ No

If yes, please provide a copy of both insurance plan ID cards so the primary plan can be determined.

CHILD'S BEHAVIORAL INFORMATION

Information is used for assessment/evaluation and will not affect the child's eligibility for BWF services.

Please check any of the following behaviors the child displays:

☐ Aggressive behaviors (toward others or objects) ☐ Hyperactivity

☐ Anxiety (control/transition/coping difficulties) ☐ Self-injurious behaviors

☐ Self-stimulatory behaviors (repetitive movements or sounds) For those checked, please explain:

Does the child:	Never	Seldom	Sometimes	Often	Always
Use gestures (bye-bye, pointing, etc.)	☐	☐	☐	☐	☐
Babble	☐	☐	☐	☐	☐
Use phrases to request	☐	☐	☐	☐	☐
Ask questions	☐	☐	☐	☐	☐
Play with toys appropriately/independently	☐	☐	☐	☐	☐
Play interactively w/siblings	☐	☐	☐	☐	☐
Play interactively w/peers	☐	☐	☐	☐	☐

Child's most preferred toys, foods or activities

Child's eating habits, variety of foods accepted and independence with feeding

Child's sleeping patterns and routines

Child's strengths

Areas of concern

Please indicate if any of the following contribute to stress/anxiety for the child:

☐ Exposure to Alcohol
☐ Exposure to Illicit Drugs
☐ Exposure to Nicotine
☐ Family /Financial Difficulties
☐ None
☐ Loss/Death of Friend or Pet
☐ Loss/Death of Family Member
☐ Moves to Different School
☐ Moves to Different Home
☐ Multiple Absences/Tardy
☐ Parent Separation/Divorce
☐ Physical/Verbal or Sexual Abuse
☐ Social Problems or Bullying

Other stressors:

_____

SCHOOL AND THERAPY INFORMATION

School_____ISD_____Grade_____

Teacher_____Counselor_____

Briefly describe the following*:*

Child's school placement (self-contained classroom, integrated, etc. Please include the number of days and times the child attends) _____

_____

Academic performance _____

Behavior in school _____

Current Therapy Services Provided by the School –
please provide a copy of the current IEP

Speech Therapy number of hours per week _____
Occupational Therapy number of hours of per week _____
Physical Therapy number of hours per week _____
Any Other Therapy Type_____and number of hours per week _____

Current and Past Private Therapy Providers NOT Provided by the School –
please provide a copy of any evaluations and treatment plans associated with each therapy

Therapy	Provider Name	Dates Attended	# Hrs. per Week
ABA			
Speech			
Occupational			
Physical			
Mental Health			
Feeding			
Other			

CHILD HISTORY AND INFORMATION

Are all recommended/required immunizations up to date? ☐Yes ☐No
If No, please list which one are not up to date: _____

Child's Current pediatrician _____Phone # _____

Are there any other physicians currently treating the child? ☐Yes ☐No
If Yes, please provide name of physician and type of treatment:

Family Medical - please indicate if the parents or anyone on either side of the family has a history of:

☐Alcoholism	☐Depression	☐Neurological Disorder
☐Anxiety	☐Disabilities/Dyslexia	☐Schizophrenia
☐ADD/ADHD	☐Drug Abuse	☐Seizures
☐Asperger Syndrome	☐Genetic Syndrome	☐Speech/Language Disorder
☐Autism/PDD-NOS	☐Intellectual Disability	☐None
☐Bipolar Disorder	☐Learning Disability	

Do any of the child's biological siblings have learning, speech, or behavior issues? ☐Yes ☐No
If Yes, please describe:

The Brent Woodall Foundation for Exceptional Children
AUTHORIZATION TO RELEASE THERAPEUTIC INFORMATION

I hereby authorize the Brent Woodall Foundation to release and discuss the child's confidential information with the following (please list name, phone#, and if a family/friend the relationship):

☐3rd Party Funding Sources (Insurance Companies, Health Plans and Grant Organizations)
☐Child's School _____
☐Other Providers _____
☐Family/Friends_____
☐I do not give my permission to release information to anyone other than the 3rd Party Funding Sources

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization and understand that prior actions taken in reliance on this authorization by entities that had permission to access this health information will not be affected.

_____

Parent/Legal Guardian Signature **Date** **Relationship to Child**