UW AUTISM CENTER

UNIVERSITY of WASHINGTON

ABA INTAKE PACKET

Welcome to the University of Washington Autism Center!

Thank you for your interest in our clinical services at the University of Washington Autism Center! To help in the first few steps of the intake process, here is a little bit of information about our ABA services and the intake process.

Filling out the Registration Form provides us with all the information needed to get you on the waitlist(s) for services. We have also attached additional intake forms specific to the service(s) you have expressed interest in. These forms will provide the clinician with important information about the client and as such, we require that the additional paperwork be turned in prior to scheduling. Below we have provided a list of our services and brief descriptions of each to aid in deciding what services you may be interested in pursuing at our Center:

- **Infant Clinic:** A clinic for children 24 months and younger dedicated to early detection, monitoring, and intervention when concerns about Autism Spectrum Disorder are present.
- **Social Skills Group:** Small group programs provide children with tools for navigating their social environment**.**
- **Applied Behavior Analysis (ABA) Intervention Services:** Our Behavior and Education Consultants (BEC) provide evidence-based treatment based on the principles of applied behavioral analysis (ABA), in order to identify individualized goals to support skill acquisition and address challenging behaviors, develop learning activities and support individuals with autism in a variety of settings.
    - ***Short Term Consultation:*** Can include problem focused parent coaching or school consultations.
    - ***Parent Coaching:*** Consultants work with parents to implement ABA-based techniques in the home.
    - ***Client-Focused Skills Coaching:*** Consultants work directly with the client on specific identified skills
    - ***Intensive In-Home ABA Program:*** Individualized home program supervision and training.

Thank you again for you interest in our services. Please don't hesitate to contact the intake coordinator with any questions or concerns. We look forward to working with you and your family!

Intake Coordinator
Office: (206) 616 – 8642 Fax: (206) 598 - 7815
Email: uwautism@u.washington.edu

INTERPRETIVE SERVICES

_____ (Name of Intake Personnel) have read or conveyed to the client/patient designee the option to access interpretive service or seek reasonable accommodation in the completion of this intake interview and document completion process.

At the time of this intake I have been given the opportunity to identify the need to access additional interpretive service or reasonable accommodations to ensure the appropriate level of service delivery. Those services have been identified below: _____ *(client initials).*

◯No additional services are needed at this time

◯Yes, I would like to discuss additional interpretive services or reasonable accommodations:

_____

_____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Seattle Office
Box 357920 Seattle, WA 98195-7920
206.221.6806 fax 206.598.7815

Toll-free Information Line 1.877.408.UWAC
uwautism@uw.edu
http://depts.washington.edu/uwautism

Tacoma Satellite
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253.692.4721 fax 253.692.4718

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ABA INTAKE FORM

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ABA Clinical Services Intervention Intake Form

Person Completing this Form

Name: _____ Please indicate relationship to the client: ☐Parent ☐ Guardian ☐ Other:_____

Are you authorized to consent for this individual's healthcare? ____ No ____ Yes

Client Information

Client Name: _____, _____

Date of Birth: _____ / _____ / _____

Address: _____

Please answer the following questions about the child's living situation:

A. Are the child's parents Divorced/Separated? ____ No ____ Yes
   1) If Divorced/Separated:
      Who is responsible for making medical decisions for the child? ____ Joint ____ Sole
      If sole custody, please specify which parent: _____
      With whom does the child reside? _____

B. Household 1: _____% time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

C. Household 2**:** _____ % time
   Name of Parent or Guardian #1: _____
   Name of Parent or Guardian #2: _____
   Names, ages, and relation to child of all other individuals in the home:
   _____
   _____

D. Are both parents aware of services being sought at the Autism Center? ____ No ____ Yes
   Does your child have a Guardian Ad Litem? ____ No ____ Yes
   If Yes, please provide their name: _____

E. Names and ages of any other siblings:
   _____
   _____

F. Primary Language: □ English □ Other: specify _____
   Percent time child is exposed to non-English language(s): _____%

Previous Evaluations/Assessments

Please list any school testing and/ or other evaluations of the client's skills.

1. Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor? ___ No ___ Yes ___ Unknown

   If yes, please provide the following information:

   A. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services: _____
   Results of Evaluation: _____
   _____

   B. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services: _____
   Results of Evaluation: _____
   _____

   C. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services: _____
   Results of Evaluation: _____
   _____

Educational History

Please list the schools attended from most recent.

1. Is the client currently enrolled in school or Birth-3 Services? __ No __ Yes __ N/A
   School Name: _____ School District: _____
   Program or Grade level: _____

2. Please list any other schools that the client has attended:

   A. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

   B. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

   C. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

3. Is the client receiving or has the client received special services or accommodations at school? ___ No ___ Yes

   If yes, please explain what type: (e.g. IEP, IFSP, 504 Plan) _____
   _____
   _____

Client's Interests

Please indicate anything that the clinicians should know when working with him/her.

1. Preferences (favorite activities, food, interests/topics, sensory):

_____
_____
_____
_____

2. Dislikes (aversions):

_____
_____
_____
_____

3. Other:

_____
_____
_____
_____

Concerns

1. Reason for seeking ABA Services [Please explain]:

_____
_____
_____
_____

2. Please list client strengths:

_____
_____
_____
_____

3. Developmental Concerns [Please indicate by marking the box and explaining each domain]

☐Cognitive/Learning	☐Motor

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☐Behavior

☐Language

☐Social

☐Peer Interaction

☐Play/Leisure

☐Self-Help (Dressing/Toileting/Feeding/Etc.)

☐Dietary/ Allergies

☐Other

☐Academics (Reading/Writing/Math)

☐Executive Functioning (Organization/Flexibility/Attention)

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Description of Services

Applied Behavior Analysis (ABA) Intervention Services: Behavior and Education Consultants (BCBAs) provide evidence-based treatment using Applied Behavior Analysis (ABA) strategies to teach new skills, develop meaningful learning tasks, address challenging behavior, and support individuals with autism in a variety of settings.

- ☐ Client-Focused Skills Coaching: BCBAs work directly with the client to build specific skills. This type of therapy is only appropriate when recommended by your BCBA and may not be the best fit for all clients.

- ☐ Intensive In-Home ABA Program: The BCBA works with families to develop, implement, and refine an in-home, intensive, comprehensive ABA-based programs individualized for each child. Home-based programs are implemented by behavior technicians and supervised by the BCBA.

Hours of Availability

Please mark the times you and the client **ARE** available for services.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					
6:00 pm					

Additional Comments

_____

_____

_____

_____

_____

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Cultural Considerations

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship.

_____
_____
_____
_____
_____

Evaluations/Assessment Reports

Please attach a copy of your insurance card (front and back)

☐Check that a copy of each side is included with this packet

Please attach a copy of your child's reports (please include all that apply):

☐Diagnostic Evaluation Report

☐IEP/IFSP/504 Plan

☐Functional Behavior Assessment (FBA) /Behavior Intervention Plan (BIP)

☐Prescription for ABA

☐Mental health directives

☐Medical advance directives

☐Powers of attorney

☐Discharge summaries or evaluations from any and all inpatient/outpatient services within the last 5 years

☐Least restrictive alternative orders

☐Other: _____

Coordination of Care

Please list and provide contact info for all other providers for your child:

☐Primary care provider: _____ Contact: _____

☐School teacher: _____ Contact: _____

☐Speech Language Pathologist: _____ Contact: _____

☐Occupational Therapist: _____ Contact: _____

☐Other: _____ Contact: _____

☐Other: _____ Contact: _____

☐Other: _____ Contact: _____

Please list any medications your child is taking, the purpose of the medication, dosage and any concerns:

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INSURANCE BILLING INFORMATION and AUTHORIZATION

◯ I am a private pay client and acknowledge it is my personal responsibility to pay for services.

- Board Certified Behavior Analyst hourly fee is $152 per hour for assessments, consultations, supervision, meetings, and therapy.
- Applied Behavior Analysis Behavior Technician fee is $54 per hour.

◯ *I authorize my insurance provider(s) listed below to make payments directly to UW Autism Center for services rendered.*

◯ *I understand that a copy of my insurance card (front and back) will be retained in my client/patient file for billing purposes.*

◯ *I agree that private information may be shared with my insurance carrier for billing purposes.*

◯ *I understand that if I do not want information shared that I may submit specific direction to UW Autism Center (UW Autism Center) (See UW Autism Center Release Form).*

Name of Primary Sponsor: _____SS# _____

Name of Insurance Carrier _____Policy # _____

Name of Secondary Sponsor: _____SS# _____

Name of Insurance Carrier _____Policy # _____

Medicare/Medicaid Identification# _____

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PATIENT / CLIENT SUPPLEMENTAL INFORMATION

[*WAC 388-877-0610- (2) g-i*]

Has the client or any family member been court ordered to mental health or chemical dependency treatment?

◯ Yes ◯ No
If Yes, please provide details and a copy of the court documents:
_____
_____

Is the client or any family member under department of corrections supervision?
◯ Yes ◯ No
If Yes, please provide details:
_____
_____

Does the client and/or family member have a history of substance abuse, including tobacco?
◯ Yes ◯ No
If Yes, please provide details:
_____
_____

Does the client and/or family member have a history of pathological gambling?
◯ Yes ◯ No
If Yes, please provide details:
_____
_____

Has the client been identified to be at risk of harm to self and/or others, including suicide and/or homicide?
◯ Yes ◯ No
If Yes, please provide details:
_____
_____

Does the client have any history of trauma or abuse?
◯ Yes ◯ No
If Yes, please provide details:
_____
_____

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Parent / Family Preferences

Please list the top three areas/goals you would like to see improvement for the client in next 6 months:

1.

2.

3.

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INFORMATION DISCLOSURE TO CLIENTS

WAC 388-877-0640 (1) under RCW 18.19.060

Purpose and Approach to Treatment:

Thank you for choosing UW Autism Center as your ABA Therapy Provider. At UW Autism Center our mission is to promote progress for every client; progress that is based in science and enhanced by the personal touch of our staff members. We strive to become Washington's leading Autism Treatment Agency by delivering our model of client-centered, individualized, wraparound therapeutic services. We create individualized programs for all our clients based on a thorough functional assessment of their strengths and weaknesses. We develop fun and exciting learning environments so that every patient/client can reach their full potential.

Individual Providers

UW Autism Center provides Board Certified Behavior Analysts (BCBA) to serve as Program Supervisors. BCBA's are responsible for conducting detailed data-based assessments, overseeing the quality and direction of the clients' therapy programs, consulting with family members and other caregivers in order to provide guidance and ensure progress, analyzing daily data collection and decision-making based on the data collected during all therapy sessions. UW Autism Center ensures that all Board Certified Behavior Analysts are current with their certification and maintain their continuing education requirements to maintain certification with the Behavior Analyst Certification Board [BACB].

Also provided are behaviorally-trained ABA Therapists to conduct ABA therapy sessions and sessions in other areas on a regular basis. Behavior Technicians must have completed a minimum of 12 semester hours (or equivalent) of college coursework and currently be enrolled in course of study leading to an associate's or bachelor's degree (psychology, education, social work, behavioral sciences, human development or related fields) Have completed a minimum of 48 semester hours (or equivalent) of college coursework. Upon hire, an additional 40 hours of classroom training and supervised fieldwork is required. Copies of licenses, trainings and certifications are stored in each employee's file. Most of our Behavior Technicians hold a degree in the Behavioral Sciences, Psychology or a related field such as; Education, Human Development, or Social Work/Behavioral Health.

UW Autism Center is licensed by the Department of Social and Health Services, Division of Behavioral Health Resources as a Licensed Behavioral Health Agency, and is also certified by the Department of Social and Health Services, Division of Behavioral Health Resources to deliver ABA services. Each BCBA and Behavior Technician are granted a Behavioral Health Agency Affiliated Registration by the Washington Department of Health. A BCBA or Behavior Technician are NOT qualified to diagnose a mental/behavioral health condition.

Client Rights (WAC 388-877-0600; WAC 388-877-0680) See attached Client Rights.

As a patient/client receiving services in the State of Washington, you have the right to: 1) Choose the provider and treatment approach that best suits your needs and purposes; 2) have full and complete knowledge of your provider's qualifications and training; 3) be fully informed as to the terms under which services will be provided; and 4) refuse treatment.

You may file a complaint with the UW Autism Center or with the Division of Behavioral Health and Recovery (DBHR) by sending a letter, calling, or emailing. We will not retaliate against you for filing a complaint.

UW Autism Center Compliance Officer; Box 357920; Seattle, WA 98195-7920
206-221-6806, Toll-Free: 877-408-8922; Email: uwautism@uw.edu

Division of Behavioral Health and Recovery;
Complaint Manager: 360-725-3752
Email: DBHRcomplaintmgr@dshs.wa.gov

Department of Health
Health Systems Quality Assurance (HSQA)
Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
360-236-4700
Email: HSQAComplaintIntake@doh.wa.gov

Reporting and Documentation of Suspected Abuse, Neglect, & Exploitation [*WAC 388-877-0420 (11)*]

Employees of UW Autism Center are notified upon their employment that they are required by law (RCW: Chapters 26.44 and 73.34) to report suspected abuse to their manager and/or appropriate state or local authorities. All clinical records will contain proper documentation pertaining to suspected abuse. Please refer to Job Description Documents for details on how to report abuse. All cases will be reported/debriefed to the Director of ABA Services, and documented in the patient/client file.

Referral Resources
Assessments and referrals for ABA therapy can be obtained by an appropriate provider type including: psychiatrist, developmental pediatricians, pediatric neurologists, and psychologists trained in the diagnosis of Autism Spectrum Disorders. The Washington State Health Care Authority has a comprehensive list of Centers of Excellence for Autism at:
http://www.hca.wa.gov/medicaid/abatherapy/Documents/HCA_Centers_of_Excellence_for_ASD.pdf

The Washington State Licensing Department asks that you be informed of the following: "Licensed providers practicing for a fee must be credentialed with the Department of Health for the protection of the public health and safety. Credentialing of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment."

Client Communication Agreement

The UW Autism Center would like to know your preferences by which we may contact you regarding your services.

I do not have a preference, UW Autism Center may contact me using either email or phone ☐ No ☐ Yes

I prefer the majority of all contact to take place via phone ☐ No ☐ Yes
If yes, please indicate below best contact number(s):

Home Number:_____ Best time(s) to call: _____
Is it ok to leave a message at this number? ☐ No ☐ Yes

Work Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ☐ No ☐ Yes

Cell Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ☐ No ☐ Yes

I prefer the majority of all contact to take place via email ☐ No ☐ Yes
If yes, please review and sign the consent for email below:

Individual Providers and clients may decide to use email to facilitate communication. Some Providers at UW Autism Center may communicate via email, but this agreement does not obligate all UW Autism Center Providers to communicate via email. Email may be one of many forms of communication with UW Autism Center.

Risk of using email
I want to use email to communicate to UW Autism Center Providers and staff about my/the client's personal health care. I understand that UW Autism Center Providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may affect the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.

Conditions for the use of email
I agree that I must not use email for medical emergencies or to send time sensitive information to my/the client's Providers. I understand and agree that it is my responsibility to follow up with UW Autism Center Providers or staff, if I have not received a response to my email within a reasonable time period.

I agree that the content of my email messages should state my question or concern briefly and clearly and include (1) the subject of the message in the subject line, and (2) clear identification including client's name, parent's name, and telephone number in the body of the message. I agree it is my responsibility to inform UW Autism Center of any changes to my email address. I agree that, if I want to withdraw my consent to use email communications about my/the client's healthcare, it is my responsibility to inform my/the client's Providers or staff member only by email or written communication

Understanding the use of email
I give permission to UW Autism Center Providers and staff to send me email messages that include my/the client's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the client, whenever necessary.

Email address: _____

Print client's name_____

_____

Signature (Parent/Guardian if under 18) **Date**

_____

Printed Name **Relationship to client**

_____

Signature of Client (if client is 13yrs or older) **Date**

SIGNATURE and ACKNOWLEDGEMENT

Parent/Guardian Signature: _____ Date: _____
I hereby certify that the above statements are true and correct to the best of my knowledge and understand all information in this packet will become part of the patient's clinical file.

Parent/Guardian Name:
_____

BCBA/Supervisor Signature: _____ Date: _____
by signing, I hereby confirm that I have reviewed with the parent/guardian the information set forth in this document and understand all information in this packet will become part of the patient's clinical file.

BCBA/Supervisor Name: _____

BCBA Certificate #_____ DOH Counselor Agency Affiliate License #_____

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