The Richard B. Funk
Center for Great Expectations

Providing the foundation for child and family success!

●1501 N. Belcher Road, Suite 249, Clearwater, FL 33765
●Phone (727) 799-3330 ext.7622 ● Fax: 727-799-9204 ●https://www.thearctb.org/

Hello and thank you for choosing The Richard B. Funk Center for Great Expectations at The Arc Tampa Bay. Thank you for the trust that you are placing in us to assist you and your family.

Please fill out all necessary forms before coming to your free intake so that our staff has all the information to provide you and your child with a comprehensive appointment.

The attached packet of information will help inform you about The Richard B. Funk Center for Great Expectations (The CGE) policies and procedures and allow you time to gather information prior to your intake appointment.

This information will be shared with the Board-Certified Behavior Analyst (BCBA) assigned to your case, should you proceed with Applied Behavior Analysis (ABA) therapy, prior to your initial meeting with them. In each instance the BCBA is responsible professionally for all services provided to you and your child.

We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be to assist you and your family. If at any time in this process you have any questions, please contact us. We look forward to meeting you and your child.

Sincerely,

The Staff at The Richard B. Funk Center for Great Expectations
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Clearwater, FL 33765
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Documents Needed:

- Completed intake for ABA therapy
- Diagnostic Report/ CDE - Needs to be done by a psychiatrist, psychologist or a developmental pediatrician. For more specific information regarding CDE requirements go to the link below - http://fl.eghs.com/Portals/1/Forms/AHCA%20Bulletin-BA%20CDE%20Requirements%209-19-19.pdf
- Most recent IEP (if there is one)
- Copy of your insurance card
- Prescription with your child's name, DOB and a diagnosis code (ICD-9) signed by PCP. Needs to say as reason: Evaluate and Treat with ABA services.

No requests for authorizations will be submitted until all the required documentation has been turned in.

**If you are a private pay client, please contact us as the process differs from what is listed above. **

Please keep in mind that the process of requesting authorization for services can be lengthy, we ask for your patience during this time.

If you have any additional questions, please feel free to contact:

Makiya Spencer M.S., Board Certified Behavior Analyst, The Richard B. Funk Center for Great Expectations
E: mspencer@thearctb.org P: 727-637-7838

We look forward to hearing from you!

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Consent and Agreement for Assessment and Evaluation

I, _____, agree to allow The Richard B. Funk Center for Great Expectations staff to perform the following services:

___ Assessment, or Evaluation ___ Report writing ___ Other (describe): _____

This agreement concerns:

_____
Name DOB

I understand that these services may include direct, face-to-face contact, interviewing, or evaluation. They may also include the analyst's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, and any other activities to support these services.

I understand that this evaluation is to be done for the purpose(s) of:
1. Assessment of current skill level
2. Assessment of any concerning behaviors.
3. Recommendations for amount of Applied Behavior Analysis Treatment

I also understand The Staff at The CGE agrees to the following:

1. The procedures for selecting, giving, and scoring the assessments, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the rules and guidelines of HIPAA and the Behavior Analyst Certification Board.
2. Assessments that are used are reliable and valid
3. These assessments will be given and scored according to the instructions in the manuals, so that valid scores will be obtained. These scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
4. Tests and test results will be kept confidential and in a safe place.
5. Assessment results will be shared with insurance companies for purposes of reimbursement and approval of services.

I agree to help as much as I can, by supplying full answers, making an honest effort, and working as best I can to make sure that the findings are accurate.

_____
Signature of client (or Parent/Guardian) Date

_____
Signature of BCBA Date

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ABA Clinic Intake

Today's Date:		**Client's Name:**			
Date of Birth:		**Current Age:**		**Client's Nickname:**	
Current Diagnoses:		**Address:**			

Insurance Company Information – Primary Coverage						
Full name of Policy Holder (if not client – name on the insurance card):						
Date of Birth of Policy holder:				Gender:		
Client relationship to the insured:	☐ self	☐ parent	☐ other	Under employer's plan:	☐ yes	☐ no
Employer's name:						
Insurance Name:		Insurance Phone Number:				
Insurance Address:						
Member ID number:		Group number:				

Insurance Company Information – Secondary Coverage						
Full name of Policy Holder (if not client – name on the insurance card):						
Date of Birth of Policy holder:				Gender:		
Client relationship to the insured:	☐ self	☐ parent	☐ other	Under employer's plan:	☐ yes	☐ no
Employer's name:						
Insurance Name:		Insurance Phone Number:				
Insurance Address:						
Member ID number:		Group number:				

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FAMILY INFORMATION:

Guardian's Name:		Relationship:	
Contact Numbers:			
E-mail:			
Occupation:			
Address (if different from client):			
Language spoken at home:		Level of Education Completed:	

Guardian's Name:		Relationship:	
Contact Numbers:			
E-mail:			
Occupation:			
Address (if different from client):			
Language spoken at home:		Level of Education Completed:	

Marital Status of parents (If in the picture)	☐ Married	☐ Separated	☐ Divorced	☐ Re-married	☐ Single parent
If parents are no longer together what is the custody arrangement?					
Was the child adopted:	☐ yes	☐ no	Provide more information:		
Is there a history of DCF involvement?	☐ yes	☐ no	Provide more information:		

Who lives at home with the child?					
Name:		Age:		Relationship to the child:	
Name:		Age:		Relationship to the child:	
Name:		Age:		Relationship to the child:	
Name:		Age:		Relationship to the child:	
Name:		Age:		Relationship to the child:	
Name:		Age:		Relationship to the child:	
Name:		Age:		Relationship to the child:	

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Any other details regarding the **FAMILY/HOME ENVIRONMENT** that you feel we should be aware of to better serve your child:

SCHOOL INFORMATION:

Type of school:	☐ Public	☐ Private	☐ Home school	☐ Other:
Name of the School:		School District/County:		
Grade:		Placement/What kind of classroom is he/she in?		
How long has the client been at this school:		Date of most recent IEP:		
Days and times of attendance:		Teacher's name:		

Any other details regarding your child's **SCHOOL** that you feel we should be aware of to better serve your child:

RELATED SERVICES - Current and past services received (e.g., ABA, OT, SLP) Service/Therapy:

If no services have been received previously, leave blank

Type of therapy:	☐ ABA	☐ Speech Therapy	☐ Occupational Therapy	☐ Physical Therapy		
	☐ Other:		☐ Other:			
	☐ Other:		☐ Other:			
Dates of Service:	From:	To:	☐ Still receiving services			
Agency name:		Therapist name:				
May we contact them:	☐ yes	☐ no	Contact information:			
Hours per week:		Location of services:	☐ home	☐ clinic	☐ school	☐ other
Progress observed:						
Type of therapy:	☐ ABA	☐ Speech Therapy	☐ Occupational Therapy	☐ Physical Therapy		
	☐ Other:		☐ Other:			
	☐ Other:		☐ Other:			
Dates of Service:	From:	To:	☐ Still receiving services			
Agency name:		Therapist name:				
May we contact them:	☐ yes	☐ no	Contact information:			
Hours per week:		Location of services:	☐ home	☐ clinic	☐ school	☐ other

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Progress observed:
Any other details regarding your child's **OTHER THERAPIES** that you feel we should be aware of to better serve your child:

PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, of the following, and if so, who?

Yes	No	Diagnoses	Who?
		Autism Spectrum Disorders	
		Learning Problem/Disabilities	
		ADHD – ADD- Attention Problems	
		Depression & Manic-Depression	
		Behavior Problems in School	
		Anxiety Disorders (OCD, Phobias, etc.)	
		Mental Retardation	
		Psychosis/Schizophrenia	
		Substance Abuse/Dependence	
		Other Mental Health Concern (Please List)	

Has the child you are seeking services for been evaluated in the past?	☐ Yes	☐ No
If YES, please list the following information on the previous evaluation(s):		

Who Completed Evaluation?	Type of Evaluation?

If yes, what were their general findings and recommendations?
Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child:

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PRE-NATAL AND DELIVERY HISTORY

Did the birth mother receive regular pre-natal care?	☐ Yes	☐ No
Were there any complications with the Pregnancy?	☐ Yes	☐ No
If YES, please provide details:		
Was the baby full term?	☐ Yes	☐ No
If NO, please provide details:		

Type of Delivery	☐ Spontaneous	☐ Induced	☐ C-Section
Any complications	☐ Yes	☐ No	
If YES, please provide details:			

Birth weight:		Any concerns at birth	☐ Yes	☐ No
If YES, please provide details – including any treatments given (Additional space on back if needed):				
Is there any additional pre-natal or birth information that might be of assistance to us?				

Has your child ever had a seizure of unexplained period of unconsciousness?	☐ Yes	☐ No
If YES, please provide details:		
Has your child ever had a head trauma or blow to the head that cause unconsciousness or required a medical review?	☐ Yes	☐ No
If YES, please provide details:		

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DEVELOPMENTAL HISTORY:

What age did your child…?		
Sit up independently:	Age:	☐ not yet
Said 1st words:	Age:	☐ not yet
Crawl:	Age:	☐ not yet
Walk:	Age:	☐ not yet
Eat solids:	Age:	☐ not yet
Sleep through the night:	Age:	☐ not yet
Potty trained:	Age:	☐ not yet
What is your child's IQ?		☐ has not been tested

At what age did you suspect problems about your child's development? Please explain:			
Has your child exhibited any loss of skills in any area?	☐ yes	☐ no	Please explain:
What are their developmental diagnoses and at what age were they diagnosed?			
Any other details regarding your child's **DEVELOPMENTAL HISTORY** that you feel we should be aware of to better serve your child:			

MEDICAL HISTORY:

Main Physician:		What discipline:	
Is the child taking any medications?		☐ yes	☐ no

Medication name:		Dosage/ Times:		Prescribing Physician:		Used for:	
Medication name:		Dosage/ Times:		Prescribing Physician:		Used for:	
Medication name:		Dosage/ Times:		Prescribing Physician:		Used for:	
Medication name:		Dosage/ Times:		Prescribing Physician:		Used for:	
Medication name:		Dosage/ Times:		Prescribing Physician:		Used for:	

Concerns regarding his hearing?	☐ yes	☐ no	Hearing test conducted?	☐ yes	☐ no	Results:

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Concerns regarding his vision?	☐ yes	☐ no	Vision test conducted?	☐ yes	☐ no	Results:
Any childhood medical illnesses or diagnoses:	☐ yes	☐ no	Provide diagnoses and explain:			
Any allergies:	☐ yes	☐ no	List:			
List any operations, serious illnesses, injuries (especially head), hospitalizations, food allergies, ear infections, or other special conditions your child has had.						
Any other details regarding your child's **MEDICAL HISTORY** that you feel we should be aware of to better serve your child:						

PLEASE INDICATE IF YOUR CHILD IS EXPERIENCING ANY OF THE FOLLOWING:

Problems with eating	☐ Yes	☐ No
Isolated socially from peers	☐ Yes	☐ No
Problems making friends	☐ Yes	☐ No
Problems keeping friends	☐ Yes	☐ No
Problems getting to sleep	☐ Yes	☐ No
Problems controlling temper	☐ Yes	☐ No
Trouble waking up	☐ Yes	☐ No
Fatigue/tiredness during the day	☐ Yes	☐ No
Nightmares	☐ Yes	☐ No
Bed wetting	☐ Yes	☐ No
Soiling	☐ Yes	☐ No
Problems following instructions	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Unmotivated	☐ Yes	☐ No
Stress from conflict between parents	☐ Yes	☐ No
Legal situation (anyone in the family)	☐ Yes	☐ No
History of abuse	☐ Yes	☐ No
Alcohol/drug use/abuse	☐ Yes	☐ No
School concentration difficulties	☐ Yes	☐ No
Grades dropping or consistently low	☐ Yes	☐ No
Sadness or Depression	☐ Yes	☐ No

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SOCIAL AND PLAY SKILLS - Describe how your child plays:

Does your child play independently?	☐ yes	☐ no
Describe play:		
Does your child play with toys appropriately?	☐ yes	☐ no
Explain:		
Does your child attempt to involve others in play?	☐ yes	☐ no
Explain:		
Does your child engage in interactive play with other children?	☐ yes	☐ no
Explain:		
Does your child engage in pretend play?	☐ yes	☐ no
Explain:		
Any other details regarding your child's **SOCIAL SKILLS**, you feel that we should be aware of to better serve your child:		

COMMUNICATION SKILLS Describe your child's spontaneous vocalization/language:

How does your child communicate his/her needs?
How does your child communicate with you?
How does your child communicate with peers?
Any other details regarding your child's **COMMUNICATION** that you feel we should be aware of to better serve your child:

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ACADEMIC SKILLS:

How is your child doing academically?
What is he/she good at?
What do they struggle with?
What would you like us to work on?

Any other details regarding your child's **ACADEMICS** that you feel we should be aware of to better serve your child:

MOTOR SKILLS:

Can your child imitate simple gestures (e.g., clapping, waving)?	☐ yes	☐ no
Can your child move around independently?	☐ yes	☐ no
Any other details your feel that we should be aware of to better serve your child:		

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SELF HELP SKILLS:

Can your child do any of these independently?		
☐ Potty trained (urine) ☐ Potty trained bowel movement ☐ Take a bath ☐ Dress themselves	☐ Brush their teeth ☐ Wash their hands ☐ Prepare a snack ☐ Clean up after themselves ☐ Tie shoes	☐ Feed themselves ☐ Blow their nose ☐ Other: _____ ☐ Other: _____
Any skills involving self-care you feel like they should be able to do?		
Any other details regarding your child's **SELF-HELP SKILLS** that you feel we should be aware of to better serve your child:		

STRENGTHS AND WEAKNESSES:

What are your child's strengths? (Tell me awesome things about your child.)
What are your child's weaknesses? (Tell me areas of improvement for your child.)

REINFORCERS:

Tell me about your child's favorite things: **(Can include activities, toys, people, places, movies, anything they like)**

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BEHAVIORS OF CONCERN - Have you observed your child emit any of these behaviors?

Self-Injurious Behaviors	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Aggression towards others	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Property Destruction/Disruption	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Verbal Aggression (yelling, cursing)	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Ritualistic/Obsessive Behaviors	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Elopement (running off)	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Self-Stimulatory Behaviors	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Other:	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Other:	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Other:	☐ yes	☐ no	**Describe what it looks like, the intensity of it and how often does it happen?**
Where and when are the behaviors of main concern taking place?			
Any other details regarding your child's **BEHAVIORS** that you feel we should be aware of to better serve your child:			

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POSSIBLE FUNCTIONS:

Check off the reasons why you think your child is engaging in the behaviors of concern.	My child does not engage in this behavior.	To get your attention or attention from those around him.	Escape or avoid doing what he/she was told/ expected to do.	To get a desired item, after being told they could not have access to something that they want, when an item they have been engaging in is taken away.	They do it whether alone or with others, regardless of whether someone is watching or not. They may engage in this behavior when there is nothing else to.	They may engage in this behavior when they are tired, thirsty or hungry.	They may engage in this behavior when they do not feel well or are in pain.
Self-Injurious Behaviors	☐	☐	☐	☐	☐	☐	☐
Aggression towards others	☐	☐	☐	☐	☐	☐	☐
Property Destruction/ Disruption	☐	☐	☐	☐	☐	☐	☐
Verbal Aggression (yelling, cursing)	☐	☐	☐	☐	☐	☐	☐
Ritualistic/ Obsessive Behaviors	☐	☐	☐	☐	☐	☐	☐
Elopement (running off)	☐	☐	☐	☐	☐	☐	☐
Self-Stimulatory Behaviors	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

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Any other concerns or information that you think it would be good to know about your child….

NEED FOR SERVICES AND AVAILABILITY:

Why are you seeking behavior analysis services for your child?

How many hours of therapy per week are you looking for?	
☐ 2-4 hours per week ☐ 5-8 hours per week ☐ 10-15 hours per week	☐ 15-25 hours per week ☐ 25+ hours per week

What is your availability for services?				
Monday	Tuesday	Wednesday	Thursday	Friday
☐ Morning	☐ Morning	☐ Morning	☐ Morning	☐ Morning
☐ Early Afternoon	☐ Early Afternoon	☐ Early Afternoon	☐ Early Afternoon	☐ Early Afternoon
☐ Late Afternoon	☐ Late Afternoon	☐ Late Afternoon	☐ Late Afternoon	☐ Late Afternoon
☐ Not available	☐ Not available	☐ Not available	☐ Not available	☐ Not available

Any other details regarding your **AVAILABILITY AND SCHEDULING** that you feel we should be aware of to better serve your child:

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