Abilities First
Intake Packet Instructions

Before your evaluation:

- ☐ Fill out the Intake Packet and send to intake@abilitiesfirst.org BEFORE your evaluation

What to bring to your evaluation:

- ☐ Insurance Card
- ☐ If you've had/have services elsewhere, please bring a most recent evaluation and progress note for your therapist to review.

Intake Packet Instructions:

- Use the fillable form to input all the information online and save as a PDF. Leaving critical information blank can slow down your child's intake.

- In fields that require your signature, just type your full name. This will represent your signature and you will sign a form to this effect when you finalize your paperwork onsite.

- Once you have filled in all the relevant fields, save the document in a place where you know you can retrieve it. If a certain section does not apply to our child, please use "NA" in the provided space.

- Attach the completed form to an email and email it to **intake@abilitiesfirst.org**. The subject line should read, "Intake Packet"
    - **if you do not feel comfortable with sending your information through email, please bring the filled out packet to your child's evaluation.

- You should receive a confirmation email about your evaluation appointment from Abilities First within two business days. If you have not received confirmation, please follow up with a call to **513-423-9496 x 226.**

  **** If you need any help filling out the forms, please don't hesitate to reach out for help. You can also download and print this form from our website if that is easier. ****

For any questions about your scheduled evaluation, please reach out to our intake coordinator at intake@abilitiesfirst.org or 513-423-9496 ext. 226

Abilities First Pediatric Therapies/Autism Learning Center
GENERAL INFORMATION

Date: _______________

Child's Name: ____
Last First Middle

Gender: ___________**Child's Social Security #** ______________ **Birthdate**: ______________

Referring Physician: ____

Medical Diagnoses:____

Parent/Guardian Information:

Parent/Guardian: _______________________________ Relationship to Child: ______________
Birthdate: ___________________

Cell Number: ______________________Email: ____

Parent/Guardian: _______________________________ Relationship to Child: ______________
Birthdate: ___________________

Cell Number: ______________________Email: ____

Address: ____

City: _____________________ State: ______ Zip code: ___________ County _______________

*You will receive weekly appointment reminders through email; however, what is your preferred method of contact for any other encounters? **Check one:** ___call ___email

What is the primary funding source for therapy services for your child?
__ Insurance __ Medicaid __ CareSource __ BCMH __ Self
Other: ____

Community Resources Checklist: (Please check the resources you are connected with)

___ Your County Board of Developmental Disabilities ___ Ohio DODD
___ OhioRise ___ Help Me Grow ___ Vocational Rehabilitation

****We gather the following information for reporting purposes to our Grant Funders:**
Race:

__ White/Caucasian __ Black/African American __ Asian __ Multi-Racial

__ Native Hawaii/Pacific Islander __ American Indian/Alaskan Native __ Other

Ethnicity: __ Hispanic __ Non-Hispanic

Household Income:

__ $0-$9,999 __ $10,000-$14,999 __ $15,000-$24,999

__ $25,000-$34,999 __ $35,000 & Above __ Unknown

Abilities First Pediatric Therapies/Autism Learning Center Case History Date ___/___/___

Identifying Information:
Child's Name:

____
Last First Middle

Preferred name: _________________ Gender: _______________ Birthdate: ___/___/___

Diagnoses: ____

With whom does your child live? ____

Relationship to child: ____

Name of legal guardian(s):____

Sibling Information:
Name: ____________________________ Age: _______ Do they live in same household? _____
Name: ____________________________ Age: _______ Do they live in same household? _____
Name: ____________________________ Age: _______ Do they live in same household? _____
Name: ____________________________ Age: _______ Do they live in same household? _____

School Information:
In what school district do you live? ____

If attending daycare, what is the name of the daycare? ___________________________

If attending school/pre-school, what is the name of the school? ___________________

Habits and Personality:
What does your child like to do?____
____
How does your child express unhappiness, anger, frustration? _______________________
____

Sleep patterns: How long? ________________ Where does your child sleep? ___________________

Parent Concerns/Expectations:
____
____
____
____

Does your child have any of the services/service plans below? And check which services were on the plan

	Plan	PT	OT	Speech	Intervention	Counseling
	Help Me Grow (IFSP)					
	IEP					
	504					

Medical and Developmental History:

Birth History:
Length of Pregnancy ___________________ Birth Weight: ___________________

Type of Delivery: _____Vaginal _____C-Section

Complications before/during/after delivery: ____

____

____

Child's Developmental History:
How was your child fed as an infant? _____ Breast _____ Bottle _____ G-tube

When were baby foods added? ____________________ When were table foods added? ___________

Was there normal weight gain? _____ Yes _____ No Does your child eat well? _____ Yes _____ No

Are there any problems such as vomiting, diarrhea, constipation or colic? ___ Yes ___ No

If yes, please indicate which one(s): ____

Nutrition: Describe briefly typical breakfast/lunch/dinner: (if a concern) __________________________

____

____

Give the age, or approximate age at which your child did the following:

Motor	**Age**		**Motor**	**Age**
Lifted head when on stomach			Walked alone	
Balanced head when propped on elbows			Climbed steps	
Rolled over (stomach to back)			Ran	
Rolled over (back to stomach)			Rode tricycle	
Sat with support			**Language**	**Age**
Sat alone			Babbled	
Crawled			Said single words	
Stood with support			Could be understood	
Stood alone			Said 3-word sentences	
Self Help	**Age**		**Self Help**	**Age**
Drank from cup			Ate with assistance	
Feed self finger foods			Toilet trained: bladder	
Feed self with spoon			bowel	

List all hospitalizations, chronic illnesses, serious injuries which may have been associated with your child's difficulties:

Age	Reason

Medical History (Continued)

Child has or has had seizures. _____Yes _____No

If yes, how often? ______________________ last known seizure?______________________

Child has allergies to the following: ____

Child's immunizations are up to date? _____ Yes _____ No

If no, give reason: ____

Child received a vision test? ___ Yes ___ No When/Where? _______________________________

Results: ____

Child has received hearing test? _____ Yes _____ No When/Where? _______________________

Results: ___ Normal or Hearing Loss: _____ Mild _____ Moderate _____ Severe

Child has frequent ear infections? ____ Yes _____ No

Child has or had PE tubes? _____ Yes _____ No If yes, when were they inserted? ______________

List all medications your child is currently taking: ** if there are more than the space allows, please attach a list of medications/supplements your child takes.

Medication/Supplement - Purpose

*Please attach any formal medical plans

Child's Name: ________________________________ Date:___________

Abilities First Pediatric Therapies/Autism Learning Center

Consent Form

Please check agree or disagree in each section and then sign bottom of form.

Consent for Treatment:

_____ Agree _____ Disagree

I give permission for my child, ____________________________,
to receive evaluation/screening/treatment by PT/OT/SLP at Abilities First.

Consent for Observation:

_____ Agree _____ Disagree

I give permission to the Pediatric Therapies program to permit students in the health professions, technicians and other such persons as the staff may deem fit to observe or be supervised in treating my child during an evaluation/ screening and/or treatment session. It is understood that any information revealed during such observations and/or supervisions will be held in strict confidence.

Consent for Continuity of Care within Abilities First:

_____ Agree _____ Disagree

I give permission to the Pediatric Therapies outpatient program therapists to share necessary and relevant medical and treatment-related information in collaboration support meetings with the Abilities First Autism Learning Center (ALC) and/or Early Childhood Learning Center (ECLC) in order to meet the child's individual needs and provide the appropriate supports in classrooms. (*Information will only be shared if your child is or will be enrolled in either ALC or ECLC.)

Consent to Photograph/Video for Abilities First public relations including social media:

_____ Agree _____ Disagree

____
Parent/Guardian

____
Date

Abilities First: Emergency Contact Information

Emergency Information

Child's Name: ______________________________ Birthdate: ____________________________

Alternative Emergency Contact

Please list an emergency contact other than parent/guardian:

Full Name: _____________________________________ Phone: ___________________________

Address: ___________________________________ Relationship: _______________________

Preferred Hospital: ____

Preferred Doctor: ______________________________ Phone: __________________________

Preferred Dentist: ______________________________ Phone: __________________________

Authorization for Emergency Care:

Authorization to seek emergency health care in the event a parent or guardian cannot be reached.

In the event that reasonable attempts made to contact me at the numbers listed above have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above doctors. In the event the above doctors are not available, another licensed doctor may provide treatment. I also authorize for my child to be transported to the above named hospital or any hospital this accessible.

This authorization does not cover major surgery unless the doctor deems it as a life threatening decision.

Parent/Guardian Signature: ______________________________________ Date: ___/___/___

Additional Instructions for Emergency Care

If you do not authorize emergency health care above, please complete this section below.

I do not give consent for emergency medical treatment of my child. In the event I cannot be contacted in an emergency situation, I wish that no action be taken or (actions you wish to be taken):

____

____

____

Parent/Guardian Signature: ______________________________________Date: ___/___/____

Client: ______________________________________ Date: ______________________________

Pediatric Therapies: Financial Agreement

- I understand that Abilities First files insurance claims on my behalf as a customer service. I agree to assist Abilities First in providing supportive documentation as request by my insurance carrier. I agree that all payments from my insurance company, Medicaid, CareSource and/or BCMH will be paid directly to Abilities First.
- I understand that I am responsible to provide immediate notification of any change in insurance policy coverage, eligibility and/or insurance carrier.
- I understand that I am expected to maintain a current Medicaid, CareSource and/or letter of eligibility from BCMH, if applicable, during the time therapy services are provided. In the event I do not receive my monthly Medicaid card renewal, I will immediately notify billing at billing@abilitiesfirst.org or 513-423-9496 ext. 120.
- I understand that I am responsible to provide a copy of my insurance card, Medicaid, CareSource and/or BCMH letter of eligibility at the beginning of every year.
- I understand payment can be made by cash, check, debit card and/or credit card (Visa, MasterCard, Discover and American Express).
- I understand delinquent payment may result in suspension of therapy service and account may be turned over to collection agency.
- I understand a $30.00 charge will be added to my account for any check returned from the bank.
- I understand that I can be provided a monthly statement indicating the services rendered, date and amount billed for such services. In the event my insurance denies payment, I accept full responsibility for the balance due within 60 days from the date of service.

<u>Billing contact information:</u>

Email: billing@abilitiesfirst.org
Phone: 513-423-9496 extension 120

______________________________	______________________	__________
Signature of Responsible Party	Relationship to Client	Date
______________________________	______________________	__________
Witness	Title	Date

Abilities First HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health and education information.

The notice contains an individual's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified and asked to sign an update.

You have the right to restrict how your protected health and education information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare and education information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health and education information may be disclosed or used for treatment, payment, educational purposes or healthcare operations.
- Abilities First reserves the right to change the privacy policy as allowed by law.
- You have the right to restrict the use of the information, but Abilities First does not have to agree to those restrictions.
- You have the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Abilities First may condition receipt of treatment upon execution of this consent

1. May we phone, e-mail or send a text to confirm appointments? ___Yes ___No
2. May we leave a message on your answering machine or cell phone? ___Yes ___No
3. May we discuss your child's medical condition with any member of the family? ___Yes ___No
4. May we discuss your child's education records with any member of the family? ___Yes ___No
   (Question 4 for Autism Learning Center Students Only)

Child's Name ______________________________ Date of Birth _________________________

This consent signed by: ____
(PRINT NAME PLEASE)

Signature:____ Date: _______________