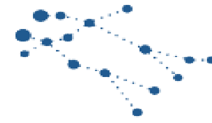
LITTLE STARS
THERAPY SERVICES



IN-HOME ABA PROGRAM INTAKE PACKET

Thank you for selecting us at Little Stars Therapy Services, LLC to help you meet the needs of your child. Thank you for the trust that you have placed in us to assist you and your family.

The attached packet of information will help inform you about Little Stars Therapy Services, LLC policies and procedures and allow you time to gather information prior to your intake appointment.

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 working alongside you and your child,

Nicole McLain, M.A., LMLP, CAS

Little Stars Therapy Services, LLC
785-534-9808

littlestarstherapyservices@gmail.com

REQUIREMENTS TO BEGIN IN-HOME ABA SERVICES ARE:

- ☐ Completed In-take Packet
  - Intake Form
  - HIPAA Service Agreement and Consent Form
  - Patient Confidentiality Contact Form
  - Payment Policy Form
  - Request/Authorization to Release Confidential Medical and Mental Health Records and Information (Optional—as needed)
  - Permission to Videotape and Photograph (Optional)
- ☐ In-Take Assessment (2-3 Hours)
- ☐ If insurance is involved then their pre-approval is required prior to any evaluation, therapy, or other service being provided.
- ☐ Family review of treatment goals and program plan
- ☐ Arrangement of schedule for in-home services

AN OVERVIEW OF LITTLE STARS THERAPY SERVICES, LLC'S APPROACH TO IN-HOME ABA

Our approach to working with each child:

- Is completely positive
- Focuses on building skills
- Is individually tailored to meet each child's unique needs
- Focuses on keeping children motivated to learn
- Uses evidence-based practices and research supported approaches

The curriculum addresses the major issues common with autism and related diagnoses, and incorporates:

- Receptive, expressive, and nonverbal language
- Attending and imitation skills
- Social skills
- Age-appropriate symbolic and play skills
- Academic skills
- Gross and Fine Motor development
- Concept Formation skills
- Environmental readiness skills

Little Stars Therapy Services, LLC supervisory staff works one-on-one with each child and closely monitors responses in order to match the difficulty of the material and method of instruction to the child's ability level and rate of learning.

In addition to the individual ABA program, parent training, programs to address problem behaviors, a range of behavior analytic services are offered through our in-home services program.

We provide behavioral assessments, parent and staff training, program supervision, school consultations, and quality monitoring for ABA in-home programs.

FINANCIAL INFORMATION

It is our policy to invoice families for co-payment monthly. Payment is due by the end of the month. Payments can be made at our monthly workshops or mailed.

There is a $40 returned check fee for all checks returned by the bank.

INFORMATION RELATED TO SCHEDULING AND SESSIONS

Sessions for in-home therapy are usually scheduled in three blocks of two or three hours (9am-11:30am; 12pm-3pm; 4pm-6pm). Research shows that longer sessions result in greater retention and this makes scheduling more convenient for all parties. If this is not convenient for your family, please bring this up during the intake meeting.

A parent/ legal guardian or designated individual over 18 is required to be present and available in the home throughout the therapy session(s).

Except in cases of emergency, 12 hours notice is required for all canceled appointments. Payment for the appointment is required for all missed appointments not canceled according to this policy. Insurance carriers are not responsible for missed appointment fees.

We request that families give us at least two weeks notice on significant changes in their plans for in-home ABA sessions schedules in order to facilitate consistency in service delivery.

Families should expect our therapists to arrive on time for their sessions, dressed appropriately, and behave respectfully. Typically, for a 3-hour session, our staff take about 10 minutes to arrange the materials prior to commencing direct therapy with the child and about 15 minutes at the end to record data, tidy the setting, and discuss the session with the parent.

The standard of care provided to our families includes program consultation, program review, and program revision as services performed by an ABA supervisor. These services are necessary for a program to meet minimum professional standards and are not optional.

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CHILD AND ADOLESCENT INTAKE QUESTIONNAIRE

CONFIDENTIAL

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information, which you think may be helpful in understanding your child. Little Stars Therapy Services, LLC will hold information provided by you as strictly confidential and will only be released in accordance with HIPAA guidelines and as mandated by law. Please use the backs of pages for additional information.

PLEASE PRINT

Name of person completing this form: ____

Legal Name of Child/Adolescent: ____

Nickname or name child routinely goes by: _____________________________________

Child's Date of Birth: ______________________ Age: _________________________

Home Address: ____

Street

_______________ ____________________ __________ ________

City County Zip State

Home telephone number: ____-_____-_______ Work phone(s) Mother: _____-_____-_____

Father: _____-______-_____

Cell phone number: Mother: ____-_____-______

Father: _____-_____-______

School Name: __________________________ District: __________________ Grade: _________

Current Teacher: _____________________________________

Who referred you to our practice? ____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

____

____

____

Indicate parent/guardians living in the home:

Marital status: Married Remarried Divorced Separated Widowed Single

If divorced, who has physical custody? ______________________ Is it full or joint? ______

Who has legal custody? ____________________ Is it full or joint? _______________

Who has legal custody? ____________________ Is it full or joint? _______________

If divorced, please provide a copy of the custody agreement.

Mother's name: ____

Date of Birth: ____

Occupation: ____

Employer: ____

Email address: ____

Education completed: _________________________ Health: Excellent Good Fair Poor

Father's name: ____

Date of Birth: ____

Occupation: ____

Employer: ____

Email address: ____

Education completed: _________________________ Health: Excellent Good Fair Poor

Do either parent's job require him/her to be away from home for long hours or extended periods?

____

siblings

Name	**Age**	**Relationship**	**Living in**	**Grade**
			Y/N	
			Y/N	
			Y/N	
			Y/N	
			Y/N	

Please list additional siblings in the above format on the back of this page.

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PSYCHOLOGICAL HISTORY:

Does your child or the mother's or father's extended family have a history of the following:

Yes	**No**	Autism Spectrum Disorder
Yes	**No**	Learning Delays/ Disabilities
Yes	**No**	ADHD/ ADD
Yes	**No**	Depression/ Manic Depression
Yes	**No**	Behavior Problems in School
Yes	**No**	Anxiety Disorders (OCD/ Phobias, etc.)
Yes	**No**	Mental Retardation
Yes	**No**	Psychosis/ Schizophrenia
Yes	**No**	Substance Abuse/ Dependence
Yes	**No**	Other Mental Health Concern (Please List)

Has your child been evaluated in the past? Yes/No

If Yes, please list the following information on the previous evaluation (s)

Who	**Type**	**When**	**Copy Available**
			Y/ N
			Y/N
			Y/N
			Y/N

(If more evaluations need to be listed, please use the space on the back of this page.)

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:

____

DEVELOPMENTAL HISTORY:

Please indicate the age at which your child did the following:

Rolled Over	Said 2-3 word phrases
Sat up unsupported	Used sentences regularly
Stood	Toilet trained during the day
Crawled	Dry through the night
Walked Unassisted	Dressed self
Said 1st word intelligible to strangers	

Please indicate if your child is experiencing any of the following:

- ☐ Problems with eating
- ☐ Isolated socially from peers
- ☐ Problems making friends
- ☐ Problems keeping friends
- ☐ Problems getting to sleep
- ☐ Problems controlling temper
- ☐ Nightmares
- ☐ Bed Wetting/ Soiling
- ☐ Problems with authority
- ☐ Anxiety
- ☐ Unmotivated
- ☐ School concentration difficulties
- ☐ Grades dropping or consistently low
- ☐ Sadness or depression

List any operation, serious illnesses, injuries, hospitalizations, allergies, ear infections, or other special conditions your child has had. ____

____

____

List any medications your child is currently taking or has taken for extended periods (give dosage level if possible: ____

____

____

Child's current height: ________ft. _____inches   Weight: __________lbs.

With which hand does your child write? ____

Does your child have any vision problems? _____________________________________

Please list the date of last vision test and who performed it (i.e., pediatrictian, optometrist, school)

____

____

Does your child have any hearing problems? _____________________________________

Please list the date of the last hearing test and who performed it (i.e., pediatrician, optometrist, school)

____

____

Name of child's physician ____

Practice Name: ____

Address: ____

Phone number: _________________________ Fax number: ____________________________

(Please list information on additional physicians on the back of the page)

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EDUCATION HISTORY:

List in chronological order all schools your child has attended:

Name	Year(s)	Grade	Special Ed?
1.			
2.			
3.			
4.			
5.			

Name of current teacher(s): ____

Does your child's teacher have concerns about him/her (list)_____________________

____

____

What is your child's favorite subject/ class? ________________________________

What is your child's least preferred subject/ class? ____________________________

Has your child ever repeated a grade? Y/N   If yes, what grade(s)?: ______________

If your child has been in Special Education, did they have a:

- ☐ 504 plan
- ☐ IEP
- ☐ Psychological Evaluation
- ☐ Special Evaluation
- ☐ Behavior Intervention Plan
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Adaptive Technology Evaluation

If your child has been in Special Education, how were they served?

- ☐ Consultation
- ☐ Collaborative Education
- ☐ Pull-out
- ☐ Special program
- ☐ Resource classroom
- ☐ Team taught classes
- ☐ Self-contained classroom
- ☐ Psycho educational center

What are your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.?

____

____

List any special abilities, skills, strengths your child has: ________________________________

____

____

DISCIPLINE INFORMATION

Parents may use a wide range of discipline strategies with children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

Intervention Type **(Very Unlikely → Very Likely)** **Effectiveness**

Intervention Type	(Very Unlikely → Very Likely)					Effectiveness
Let situation go	1	2	3	4	5	
Take away a privilege	1	2	3	4	5	
Assign an additional chore	1	2	3	4	5	
Physical punishment	1	2	3	4	5	
Send to room	1	2	3	4	5	
Reason with child	1	2	3	4	5	
Ground child	1	2	3	4	5	
Yell at child	1	2	3	4	5	
Send to time out	1	2	3	4	5	
List anything else you may do:	1	2	3	4	5	

GENERAL INFORMATION

Please list the five things you would like for your child to do more of and less of in order of priority to you.

	Like child to do more often	Like child to do less often
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________
4.	______________________	______________________