Nash Therapeutic Services, LLC

Ph. 501.500.2111
Fax: 501.244.9999
http://www.nashtherapy.net

628 W. Broadway
Suite 100
N. Little Rock, AR. 72114

Thank you for selecting Nash Therapeutic Services as your team for finding solutions. It is our desire to provide your family and your child with the tools necessary to help attenuate undesired behavior and develop effective life skills that in turn lead to more success in the home, at school/work, and in the community. We know you have many options to choose from and we appreciate you trusting us to assist you on this exciting journey.

The attached packet will help inform you about Nash Therapeutic Services' policies and procedures and allow you time to gather information prior to the assessment process. If you have questions, please contact us.

We look forward to meeting you and your child.

The intake process requires the following documentation:

- ❒ ABA Intake/Application (This packet)
- ❒ Copy of most recent Comprehensive/Psychological evaluation
- ❒ Copy of most recent Speech Therapist evaluations and goals
- ❒ Copy of most recent Medical evaluations or Well-Child Visit report
- ❒ Copy of front and back of medical insurance card
- ❒ Parent Handbook Signature Page
- ❒ Consent for Applied Behavior Analysis Services
- ❒ EPSDT (DMS-693) referral form completed by your doctor that states diagnosis and the recommendation for ABA Evaluation and Therapy.

Other helpful documentation:

- ❒ Copy of most recent IEP
- ❒ Authorization to Release information
- ❒ Copy of any additional supportive evaluations (i.e. Occupational therapist, Clinical therapist)

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ABA Intake Form

Child Information	**Today's Date:**
Last Name:	**Age: yr mth**
First Name:	**Date of Birth:**
Middle Name:	**Gender:**
	Social Security Number:
Home phone:	
Address:	
City:	
State: **Zip code:** **County:**	

Primary Diagnosis:	**Date of Diagnosis:**
Other condition:	**Date of Diagnosis:**
Other condition:	**Date of Diagnosis:**

Source of Funding	☐ **Early Intervention** ☐ **DCFS** ☐ **Medical Insurance** ☐ **Other:**				
Medical Insurance Provider					
Policy #		**Group#**		**Plan Name**	

Mother or Legal Guardian Information	
Full Name:	**Relationship to Child:**
Address: (if different from applicant)	
City:	**Occupation:**
State:	**Name of Employer:**
Home Phone: (if different from applicant)	**Business Phone:**
Cell Phone:	
Fax:	
E-mail:	

Father or Legal Guardian Information	
Full Name:	**Relationship to Child:**
Address: (if different from applicant)	
City:	**Occupation:**
State:	**Name of Employer:**
Home Phone: (if different from applicant)	**Business Phone:**
Cell Phone:	
Fax:	
E-mail:	

Applicant's Siblings:		
Name:	**Age:**	**Gender:**
Name:	**Age:**	**Gender:**
Name:	**Age:**	**Gender:**
Name:	**Age:**	**Gender:**

Present School/Placement	
Name of School:	**Years attended:**
Address:	**Placement:**
Phone:	

Medical Information

Is your child on medication? ☐ Yes ☐ No

If yes, list medication, administration times, usage:

Type of Medication	Dosage	Administration Times	Used for

Additional medications can be attached on a separate sheet of paper and stapled to this application

Has the child ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations?
☐ Yes ☐ No If yes, please explain.

Are there any medical conditions that need to be considered when delivering ABA treatment?	☐ Yes ☐ No If yes, please explain.

History of Treatment	
❒ **Behavior Consultation Provider**	Dates of service: to
Provider Agency:	-
Provider Name:	-
Provider Phone:	-
Frequency of provider consultation:	

Methods of treatment by the provider. ☐ ABA Lovaas-based ☐ ABA Verbal Behavior-based ☐ TEACCH	☐ Greenspan/Floortime Other Other

Please describe services by the provider and program information.

Please describe the results of these therapies in regards to success in achieving goals.

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❒ **Behavior Consultation Provider**	Dates of service: to
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Please describe services by the provider and program information.

Please describe the results of these therapies in regards to success in achieving goals.

Supportive Services

What other services is your child <u>currently</u> receiving both in-school and out of school? Please enclose a copy of the child's most recent IEP or IFSP and Therapy goals from each area that is checked.

Service/Therapy	Location	Minutes/Week
☐ Early Intervention Services	☐ School ☐ Home	
☐ Speech and/or language therapy	☐ School ☐ Home	
☐ Occupational and/or Physical Therapy	☐ School ☐ Home	
☐ Vision services in school	☐ School ☐ Home	
☐ Hearing services	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	

Please describe the results of these therapies in regards to success in achieving goals.

What, if any, behavior issues does your child have? Ex., self-injurious, aggressive towards others, etc., please explain. Include methods used to decrease these behaviors.

What are your immediate goals for your child?

What would you like us to know about your child?

What current communication skills does your child have? Ex., sign language, PECS, verbal, please explain

What level of commitment are you willing to make at home in order for your child to achieve these goals?

The undersigned hereby acknowledge that the information contained in this application is accurate in all respects.

Parent/Guardian (print name) _____

Signature of PARENT/GUARDIAN: _____ Date: _____

Enter SSN for Digital Signature

Please send completed form and supporting documents to:

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