



Exceptional Therapy for Exceptional Children

## Application for Home and Center Based Hourly ABA Therapies

**\*\*\*Incomplete or illegible applications and /or applications submitted without an attached diagnosis report cannot be processed. For consideration, please submit application to [abc4autism@gmail.com](mailto:abc4autism@gmail.com) or fax to 321.248.0717\*\*\***

### How did you hear about us?

Doctor referral (name) \_\_\_\_\_ Brochure (location) \_\_\_\_\_  
Facebook \_\_\_\_\_ Internet \_\_\_\_\_ Friend \_\_\_\_\_  
Insurance referral \_\_\_\_\_ Bright Feats Catalogue \_\_\_\_\_ CARD \_\_\_\_\_ Flyer \_\_\_\_\_

### Hourly therapy options (please select all that apply AND include estimated hours and times preferred per week ) \*minimum of 4 hours / week required

\_\_\_ IN HOME  
Number of hours per week \_\_\_\_\_ Days & times: \_\_\_\_\_  
\_\_\_ AT CHILDS SCHOOL / DAYCARE  
Number of hours per week \_\_\_\_\_ Days & times: \_\_\_\_\_  
\_\_\_ ON SITE AT OUR LONGWOOD LOCATION  
Number of hours per week \_\_\_\_\_ Days & times \_\_\_\_\_  
\_\_\_ ON SITE AT OUR WINTER GARDEN LOCATION  
Number of hours per week \_\_\_\_\_ Days & times \_\_\_\_\_

### Client information

Name (last): \_\_\_\_\_ First: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_  
Primary diagnosis: \_\_\_\_\_ Date diagnosed: \_\_\_\_\_ Diagnosing physician: \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_  
Secondary diagnosis: \_\_\_\_\_ Date diagnosed: \_\_\_\_\_ Diagnosing physician: \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_  
Social security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Current school attending: \_\_\_\_\_ School county: \_\_\_\_\_  
Funding source(s) for therapy (pick all that apply/ attach documentation):  
\_\_\_ Gardiner(step-up) / Annual funding amount \_\_\_\_\_ ID# \_\_\_\_\_  
\_\_\_ VPK/SIS  
\_\_\_ Health insurance  
\_\_\_ Private pay  
\_\_\_ Other  
Peanut allergy: \_\_\_\_\_ (yes or no) Does child have an epi-pen? \_\_\_\_\_ (yes or no)  
Other allergies: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Current medications: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Current / previous therapies tried: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
How does child communicate? (check all that apply): \_\_\_ PECS \_\_\_ pointing \_\_\_ gesturing  
\_\_\_ nonverbal \_\_\_ sign language \_\_\_ other  
Toilet trained (check one): \_\_\_ yes, fully \_\_\_ yes, partially(explain) \_\_\_\_\_  
\_\_\_ not toilet trained  
Does child exhibit any behavior that would be considered dangerous to himself or others?  
\_\_\_ self-injury (explain) \_\_\_\_\_

## Responsible party

Primary : Name (last): \_\_\_\_\_ First: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Social security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary: Name (last): \_\_\_\_\_ First: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Social security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact:

Name (last): \_\_\_\_\_ First: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Expectations for ABA therapy: \_\_\_\_\_

## Primary insurance information

Insurance company: \_\_\_\_\_ Policy holder name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone number for providers: \_\_\_\_\_

## Secondary insurance information

Insurance company: \_\_\_\_\_ Policy holder name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone number for providers: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Patient release & acknowledgement (initial on each line)

\_\_\_\_\_ I verify that the information I have provided is correct to the best of my knowledge

\_\_\_\_\_ I authorize the release of medical information necessary to receive benefit information, treatment authorization and in order for ABC to process claims through insurance companies and their agencies.

\_\_\_\_\_ I have attached a diagnosis report from my child's medical doctor

\_\_\_\_\_ I have completed all portions of this document and understand that incomplete or illegible

\_\_\_\_\_  
Signature of insured or authorized person

\_\_\_\_\_  
Printed name of insured or authorized person

\_\_\_\_\_  
Date

### OFFICE USE ONLY

COPAY: \_\_\_\_\_ COINS: \_\_\_\_\_ DEDUCTIBLE: \_\_\_\_\_ DED. START DATE: \_\_\_\_\_ REMAINING DEDUCTIBLE: \_\_\_\_\_ MAX OOP: \_\_\_\_\_  
RBT RATE: \_\_\_\_\_ BCABA RATE: \_\_\_\_\_ BCBA RATE: \_\_\_\_\_ MOD RATE: \_\_\_\_\_ PARENT TRAINING RATE: \_\_\_\_\_ GROUP RATE(RBT): \_\_\_\_\_

### PROGRAM DIRECTOR ONLY

LOCATION: \_\_\_\_\_

HOURS APPROVED AND CODES : \_\_\_\_\_