KALAMAZOO ACADEMY FOR BEHAVIORAL & ACADEMIC SUCCESS

NEW LEARNER ABA INTAKE PACKET

Welcome to KABAS Clinic!

Thank you for your interest in our clinical services at the Kalamazoo Academy for Behavioral and Academic Success (KABAS)! To help in the first few steps of the intake process, here is a little bit of information about our ABA services and the intake process.

We are committed to providing a positive and nurturing learning environment where all learners can thrive. Our clinical approach is based on decades of research on Applied Behavior Analysis (ABA) and the Strategic Science of Teaching (SST). Our unique, data-driven approach supports behavioral, social-emotional, and academic success for all children.

We provide in-clinic services for school-aged children (5-12 years old). Our team provides a range of services to help your child and your family. All programs are created from research-based strategies and developmentally-appropriate curriculum. The teaching of treatment goals is done one-on-one, in small or large group settings, and inside the KABAS classrooms.

Thank you again for your interest in our services. Please don't hesitate to contact the KABAS Operations Coordinator with any questions or concerns. We look forward to working with you and your family!

Office: (269) 633-9218

Email: kalamazooschool@kalamazooschool.org

INTAKE PACKET CHECKLIST

Learner Name: _____

- ABA Intake Packet
- Signed Emergency Medical Release Form
- Signed Medication Administration Form
- Signed Media Release Form
- Copy of Birth Certificate
- Copy of social security card
- Copy of insurance card(s)(front and back)
- Copy of parent or guardian's driver's license
- Copy of parent or guardian's social security card
- Proof of immunizations
- Proof of physical examination within the last year on health (health appraisal form)
- Proof of guardianship, if you are not the child's parents (Court Custody Documentation, Department of Children and Families Placement Letter, or Educational Guardianship)
- Learner's CA-60 record (i.e., IEPs) from schools

All listed documents must be submitted along with completed packet

Administrative Use:

Date Registration received: _____

Received By: _____

Amount Received: _____

Check #: _____

Received by: _____

KABAS Registration 2024-2025. Please fill out the form completely

Child's Full Name: _____

Address _____ City: _____ State: _____ Zip: _____

Date of Birth (MM/DD/YYYY): ____/____/_____ Grade: ____ Sex: _____

Social Security Number: _____

Race: (required by DOE, please check one)

Hispanic/Latin		Black or African American	
American Indian or Alaska Native		Native Hawaiian or other Pacific Islander	
Asian		White/Caucasian	

Caregiver Information

Parent/Guardian Name: _____ Relation to Student: _____ Home Address:_____ _____ _____ Daytime Phone: (___)_____ Evening Phone: (___) _____ Cell Phone: (___) _____ Email: _____	Parent/Guardian Name: _____ Relation to Student: _____ Home Address:_____ _____ _____ Daytime Phone: (___)_____ Evening Phone: (___) _____ Cell Phone: (___) _____ Email: _____
Emergency Contact #1: _____ Relation to the Student:_____ Daytime Phone: (___)_____ Evening Phone: (___) _____ Cell Phone: (___) _____	Emergency Contact #2: _____ Relation to the Student:_____ Daytime Phone: (___)_____ Evening Phone: (___) _____ Cell Phone: (___) _____

With whom does the student live? (Name) _____

In the event that the parents are not together, divorced, or become divorced, please provide and attach a copy of the legal documents regarding your child's educational decision making.

Please list the name(s) of individuals authorized to pick up your child:

Name _____ Relationship _____ Phone: _____

Name _____ Relationship _____ Phone: _____

Name _____ Relationship _____ Phone: _____

Previous Evaluations/Assessments

1. Has the client ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselor?
   ____ No ____ Yes ___ Unknown

   If yes, please provide the following information:
   A. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services:_____
   Results of Evaluation_____

   B. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services:_____
   Results of Evaluation_____

   C. Name: _____ Type of Specialist_____ Date of evaluation: _____
   Purpose of Evaluation / Services:_____
   Results of Evaluation_____

Educational History

1. Please list any schools that the client has attended:
   A. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

   B. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

   C. School Name: _____ School District: _____
   Years of attendance: _____ Grade Levels: _____

2. Has/is the client receiving or has the client received special services or accommodations at school? ____ No ____ Yes. If yes, please explain what type: (e.g. IEP, 504 Plan)
   _____

_____

Client's Interests

Please indicate anything that the clinicians should know when working with him/her.

1. Preferences (favorite activities, food, interests/topics, sensory):
   _____
   _____
   _____
2. Dislikes (aversions):
   _____
   _____
3. Other:
   _____
   _____
   _____

Concerns

1. Reason for seeking ABA Services [Please explain]:

_____
_____
_____

2. Please list client strengths:

_____
_____
_____

3. Developmental Concerns [Please indicate by marking the box and explaining each domain]

● Cognitive/Learning	● Motor	● Behavior
● Social	● Language	● Peer Interaction

• Play/leisure	• Self Help (dressing/toileting/feeding)	• Academics (reading, writing, math)
• Executive Functioning (organization, flexibility, attention)	• Dietary/Allergies	• Other

Cultural Considerations

Please describe any important cultural practices, rituals, transitions, or believe that you believe are important for us to be aware of prior to initiating a therapeutic relationship.

_____

_____

_____

_____

Coordination of Care

Please list and provide contact info for all other providers for your child:

- Primary care provider: _____ Contact: _____
- School teacher: _____ Contact: _____
- Speech Language Pathologist: _____ Contact: _____
- Occupational Therapist : _____ Contact: _____
- Other : _____ Contact: _____
- Other : _____ Contact: _____
- Other : _____ Contact: _____

INSURANCE BILLING INFORMATION and AUTHORIZATION

- I *authorize my insurance provider(s) listed below to make payments directly to the Kalamazoo Academic for Behavioral and Academic Success (KABAS) for services rendered.*

- *I understand that a copy of my insurance card (front and back) will be retained in my client/patient file for billing purposes.*

- *I agree that private information may be shared with my insurance carrier for billing purposes.*

Name of Primary Sponsor: _____SS# _____

Name of Insurance Carrier _____Policy # _____

Name of Secondary Sponsor: _____SS# _____

Name of Insurance Carrier _____Policy # _____

Medicaid Identification #_____

Reporting and Documentation of Suspected Abuse, Neglect, & Exploitation

KABAS employees are mandated reporters. They are notified upon their employment that they are required by law to report suspected abuse to their manager and/or appropriate state or local authorities. All clinical records will contain proper documentation pertaining to suspected abuse. All cases will be reported/debriefed to the Director, and documented in the patient/client file.

Emergency Medical Release Form

Child's name_____ DOB_____

(This form must accompany students to hospital in the event of emergency treatment.)

TO: WHOM IT MAY CONCERN:

I hereby grant permission for KABAS Academy staff to take whatever steps may be necessary to obtain emergency medical care for my child, if warranted. Depending on the nature and urgency of the situation these steps may include, but are not limited to, the following:

1. Attempt to contact a parent/guardian.
2. If a parent/guardian is not available, we will attempt to contact the local emergency contact listed on this form.
3. Call 911.
4. Any expenses incurred in seeking medical treatment will be the responsibility of the child's family.
5. The school will not be responsible for anything that may happen as a result of false medical or personal information given on this form.

Name of Parent(s)

_____

Home Telephone Number _____

Mother's Work Number _____ Father's Work Number _____

Mother's employer/occupation _____ Father's employer/occupation _____

Mother's Cell Number_____ Father's Cell Number_____

Name and phone number of a **local** Emergency Contact (if parents cannot be reached)

_____

**In order for someone else to seek urgent care for your child, they will need to have copies of your insurance card and may be required to have a Power of Attorney.

Relationship to Student _____ Telephone

Number(s)_____

_____ _____

Parent or Guardian Signature Date

Physician and Dentist to contact in the event of an emergency:

Name	Phone	Address

Medical History Information:

List any Allergies: Medicines_____ _____ _____ Foods_____ _____ _____ Insect sting/bite_____ _____ _____ Seasonal/environmental_____ _____	List any chronic or severe illnesses, injuries, surgeries, or hospitalizations: _____ _____ _____ _____ Please list any other pertinent health issues which may be a concern at school: _____ __ _____ _____
List all daily or routine medications other than vitamins: Does any medication need to be administered at school? No □ Yes □ What medicine?_____ _____ (If yes, please complete the "Medication Administration Form" and bring a supply of the medication to the school office)	List any need for special attention because of health related issues: _____ _____ Does your child use vision or hearing aids? If yes, what device? _____ _____ _____ _____
Date of Last Physical exam: Date of Last Tetanus shot:	Has your child ever been diagnosed with asthma by a physician? No □ Yes □ **Does your child carry an inhaler at school? No □ Yes □ What medicine?_____ **Does your child ever require nebulizer treatments at school? No □ Yes □ What medicine?_____ (If your child carries an inhaler or requires nebulizer treatments, please complete the "Medication Administration Form" and bring a supply of the medication to the school office)

I give KABAS staff permission to administer, at their discretion, the following oral medications or their generic equivalents to my child as needed during the school day, at a dose appropriate for his/her age & weight (SELECT FROM LIST BELOW):

Tylenol (acetaminophen) _YES/NO_ Benadryl (diphenhydramine) YES/NO

Motrin/Advil (ibuprofen) YES/NO___ Tums (calcium carbonate) YES/NO

Other (list it):

_____
_____

Medication Administration Form

For Medications Supplied by Parents

I _____, give permission for my child _____, to have his or her oral medication(s) administered to him or her during the school hours by a KABAS Academy school staff.

My child will need the following medication (s) and dosage (s) administered during the school hours:

Medication	Dosage	Time
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Instructions for administering the medication(s):

_____
_____
_____
_____
_____

Signed: _____ Date:_____
PHYSICIAN signature required for ALL PRESCRIPTION medications

Signed: _____ Date:_____
PARENT signature required for prescription and over-the-counter medications

Medication must be provided in its original container from the pharmacy with dosage amount, directions, and the name of the prescribing physician. Please note that if the above information is not provided the medication <u>will not</u> be administered.

N/A: This form does not apply to my child.

Signed: _____ Date:_____

Release Form

Throughout the school year, KABAS may take pictures and/or videos for the purpose of staff training, marketing, and advertising. KABAS may also have opportunities to talk about students' academic and behavioral improvements and outcomes at professional conferences or events. By signing this, you are giving KABAS permission to use copies of pictures and recordings for educational, promotional, and advertising purposes. You are also giving KABAS permission to talk about your child's educational improvements. Your child's personal information (e.g., name, age, and address) will not be disclosed. There will be no payment for any promotional materials developed during the school year. By signing this, you agree to release KABAS from liability for any claims in connection with videos or pictures taken. All copies of videos or photos taken will be provided to you before they are used.

I give KABAS permission to use academic and behavioral outcomes, pictures, and videos of my child for the following purposes (please note that your child will receive our best help, whether or not you give permission):

Please circle Yes or No for each option.

Yes	No	Public KABAS Facebook page and school website
Yes	No	Professional events/conferences
Yes	No	School newsletter
Yes	No	Staff trainings

Parent/Guardian Signature: _____ Date: _____

SIGNATURE and ACKNOWLEDGEMENT

Parent/Guardian Signature: _____ Date: _____

I hereby certify that the above statements are true and correct to the best of my knowledge and understand all information in this packet will become part of the patient's clinical file.

Parent/Guardian Name:_____

BCBA/Supervisor Signature: _____ Date: _____ *by signing, I hereby confirm that I have reviewed with the parent/guardian the information set forth in this document and understand all information in this packet will become part of the patient's clinical file.*

BCBA/Supervisor Name:_____

BCBA Certificate #_____