ASSESSMENT PACKET

INSPIRE

Center for Autism

Welcome to Inspire Center for Autism

The team at Inspire Center for Autism is highly inclusive, culturally sensitive, culturally respectful, and culturally competent. We will make every effort to ensure you and your family are treated with respect and dignity at all times, regardless of racial, ethnic or cultural customs/practices or beliefs, sexual orientation, gender, gender identity, or gender expression, disability, and/or community differences. During the referral process, Inspire Center for Autism inquired about any family considerations that our team should be made aware of. If at any time, any additional considerations arise, or considerations change, please notify the office immediately so we can do our best to respect the considerations of you and your family.

Further, Inspire Center for Autism will take reasonable steps to ensure that those with Limited English Proficiency (LEP) have meaningful access and equal opportunities to participate in the services provided by Inspire Center for Autism.

Again, we want to thank you for partnering with us and for providing us with the opportunity to help your family navigate behavior analytic services while also working together to find the best fit for your family!

If at any time during the course of services at Inspire Center for Autism you have questions or concerns or would like clarification, please do not hesitate to reach out for support.

Printed Name of Guardian:		**Date:**	
Signature:			

To continue with the intake and registration process at Inspire Center for Autism for Applied Behavior Analytic (ABA) services, please review and complete the documents included in this packet. A checklist has been provided below to assist in ensuring all requested documents are reviewed, completed and submitted.

Intake Packet Checklist			
Title of Document	**Location in Packet**	**Date Completed**	**Initials**
Welcome Page	**Page 2**		
Consent for Applied Behavior Analytic Services	**Pages 4-5**		
Patient Information Questionnaire	**Pages 6-15**		
Mandated Reporter Disclosure Form	**Page 16**		
Patient Home Safety Checklist	**Page 17-18**		

A finalized packet will be required prior to an assessment being scheduled.

Consent for Applied Behavior Analytic Services			
Patient Name:		**Date of Birth:**	
Description of Services			
What is Applied Behavior Analysis?	ABA is the science of producing significant and practical changes in behavior through the analysis, observation, design, implementation and evaluation of past and current environmental events (antecedents and consequences). Behavior analytic practices focus on the acquisition, maintenance and generalization of behaviors and/or the reduction of behaviors that impact meaningful changes.		
Assessment	Throughout all phases of treatment, consistent, ongoing, and objective assessments will take place to ensure a comprehensive understanding of each individual's baseline, present levels of performance and progress across environments. An analysis of the information obtained through the assessments will serve as the basis for ongoing treatment recommendations. Assessments conducted by the staff at Inspire Center for Autism may include, but are not limited to, parent interviews, file reviews, the Assessment of Basic Language and Learning Skills, Revised (ABLLS-R), the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), The Essentials for Living (ELS), the Assessment of Functional Living Skills (AFLS), the Vineland Adaptive Behavior Skills, and/or Functional Behavior Assessments (FBA).		
Treatment Recommendations:	Based on an individual's assessment results, treatment recommendations may vary in the number of goals, complexity, duration, and intensity and may change over time based on an individual's response to treatment. An individual treatment plan will be developed, reviewed and agreed upon prior to the implementation of any treatment components.		
Treatment Models:	**Comprehensive ABA**	Comprehensive ABA treatment typically involves 30-40 hours of direct 1:1 therapy and is designed to address multiple domains that impact an individual's ability to function at the same level as their typically developing peers. Gaining new skills (skill acquisition) and reducing barriers that may impede an individual's involvement in home, community or educational opportunities (behavior reduction) are the primary objectives within a comprehensive ABA treatment approach.	
	Focused ABA	Focused ABA treatment typically involves 10-25 hours of direct 1:1 therapy and is designed to address a limited number of domains for individuals who only need to target key functional skills or for individuals in which the priority of treatment is a reduction in significant maladaptive behaviors. The primary objectives within a focused ABA treatment approach include targets that increase independence and/or improve the health or safety of the individual or others.	

Parent Training:	Parent/caregiver training is a required component of treatment and is designed to improve an individual's ability and likelihood of implementing treatment protocols and recommendations outside of direct treatment and across environments. The primary objectives within a parent/caregiver training model are coaching, modeling, problem solving, support, and generalization using objective and measurable goals for parents/caregivers.
Data Analysis:	Throughout treatment at Inspire Center for Autism, on-going data analysis will be conducted to monitor patient progress toward treatment plan goals. Data analysis will include, but is not limited to, the review of data collection systems, summarizing and reporting patient progress towards treatment goals. Based on data analysis, the staff at Inspire Center for Autism may adjust treatment protocols and/or modify treatment recommendations.
Tiered Service Delivery Model:	Inspire Center for Autism utilizes a tiered service-delivery model, in which the Board-Certified Behavior Analyst (BCBA)® on the case designs, supervises, and provides clinical direction, while the treatment protocols are delivered by the Registered Behavior Technicians (RBT®).
Coordination of Care:	In an effort to improve patient outcomes, the staff at Inspire Center for Autism will consult and/or collaborate with other professionals involved in the patient's care. Coordination of care between professionals and family members can help ensure consistency across environments. Coordination of care may include, but is not limited to, emails, phone calls, in-person meetings, and/or trainings. Explicit consent from the patient's legal guardian to obtain and/or release information for the purpose of coordination of care will be obtained by Inspire Center for Autism prior to doing so.

I, _____, the legal guardian of _____ give consent for my child to participate in the behavior analytic services provided by Inspire Center for Autism. Participation may include, but is not limited to, assessment, treatment implementation and other services deemed necessary by Inspire Center for Autism. Services will consist of evidence-based practices, techniques and approaches in the field of Applied Behavior Analysis (ABA).

Printed Name of Guardian:		**Date:**	
Signature:		**Expiration of Consent:**	

Patient Information Questionnaire			
Date of Intake:		**Completed By:**	
Patient Name:		**Date of Birth:**	

Medical History			
Pregnancy:	☐ Normal and routine ☐ Problematic Describe any difficulties or complications during pregnancy:	**Gestation:**	The individual was born at _____weeks. The individual ☐ came home as expected ☐ was required to stay in the hospital for _____ weeks after delivery
Fetal History:	Prior to birth, the individual was exposed to: ☐ Alcohol ☐ Illicit drugs ☐ Prescription drugs ☐ Tobacco ☐ Caffeine ☐ Other ☐ Unknown ☐ None		
Birth:	☐ Vaginal birth without complications ☐ Vaginal birth with complications Describe any difficulties or complications experienced during delivery: ☐ Cesarean delivery without complications ☐ Cesarean delivery with complications Describe any difficulties or complications experienced during delivery:		
Developmental Milestones:	Did the individual meet their developmental milestones on time? ☐ Yes ☐ No If not, which domains were not met on time? ☐ Communication ☐ Social Skills ☐ Motor Skills ☐ Self-Help skills When did you become concerned about the individual's development?		

	When did medical professionals become concerned? Has your child had genetic testing? ☐ Yes ☐ No If so, what were the findings:
Hospitalizations:	☐ There individual has not been hospitalized for any medical procedures or medical conditions or behavioral emergencies ☐ The individual has been hospitalized for medical procedures, medical conditions, and/or behavioral emergencies including the following: Please include reason for hospitalization, date and length of stay ☐ N/A
Infectious Diseases:	☐ No history of infectious diseases ☐ The individual has or had the following infectious diseases that the treatment team should be made aware of:
Autoimmune Deficiencies:	☐ The individual does not have a history of any autoimmune deficiencies (i.e., PANDAs, Lyme disease, etc.) ☐ The individual has a history of autoimmune deficiencies ☐ N/A If so, have the autoimmune deficiencies been evaluated and/or treated by a medical professional: ☐ Yes ☐ No Date of last follow-up: Name of the treating physician: Please attach the current treatment plan or most recent progress notes.
History of Seizures:	☐ The individual does not have a history of seizures ☐ The individual has a history of seizures ☐ N/A If so, have the seizures been evaluated and/or treated by a medical professional: ☐ Yes ☐ No Date of last follow-up: Name of the treating physician:

	Please attach the current treatment plan or most recent progress notes.
Adaptive Devices:	☐ The individual does not require or use any adaptive devices ☐ The individual uses the following adaptive devices: ☐ Augmentative and Alternative Communication (AAC) Device ☐ Ankle Foot Orthotics (AFOs)/Leg, foot or ankle braces ☐ Glasses ☐ Hearing Aids ☐ Wheelchair/walker/forearm crutches ☐ Other:
Allergies:	☐ The individual does not have any known allergies ☐ The individual has the following allergies: Instructions for allergic reactions include:
Dietary Considerations:	Dietary Allergies: ☐ No ☐ Yes, including the following: Dietary Restrictions: ☐ No ☐ Yes, including the following: The individual experiences the following: ☐ Food selectivity (only eats specific foods, textures, colors, etc.) ☐ Food refusal (requires supplemental nutrition due to refusal to eat/drink) ☐ None of the above ☐ Other: Have the feeding concerns been evaluated and/or treated by a medical professional: ☐ Yes ☐ No ☐ Date of last follow-up: Name of the current or previous treating physician(s):

	Please attach the current treatment plan or most recent progress notes.
Sleep	Are there any sleep concerns? ☐ No ☐ Yes If yes, please explain: _____ Do they take naps? ☐ No ☐ Yes If yes, how long and what time is it during the day?_____
Family Medical History:	☐ There is no signification family medical history ☐ There is a significant family medical history, including the following:

Condition	Mother	Father	Maternal Grandparent	Paternal Grandparent	Other
Autism	☐	☐	☐	☐	☐
Intellectual disability	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Learning disability	☐	☐	☐	☐	☐
Speech/language delay	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐
Food allergies	☐	☐	☐	☐	☐
Gastrointestinal disease	☐	☐	☐	☐	☐
Other:					

Medical Professionals:	Is your child currently being seen by any other medical professionals (excluding ongoing services such as speech, OT, PT that were listed on the Referral)? ☐ No ☐ Yes If so, please list them below: Role/Specialty Name Intensity
Medications:	Please list all medications that your child is currently taking: ☐ N/A Name Dosage Frequency Reason Prescribing Physician
Previous Services:	Please list the services that the individual received in the past, but is no longer receiving: Service Dates Duration (i.e., 1 hour) Intensity (i.e., 2x/week)
Additional Considerations:	Please list any additional information you would like to share with your child's team regarding their medical history/background:
Parent Concerns:	Do you have any current medical related concerns? No Yes If so, please explain:
Educational History	
Educational Placement:	Currently attends: ☐ Daycare Name: ☐ Preschool Name: ☐ Public School Name: Grade: ☐ Private School Name: Grade:

	Does your child receive special education services? ☐ No ☐ Yes If so, where does your child receive the majority of their education: ☐ General Education ☐ Inclusion ☐ Self-Contained Schedule at current placement: ☐ Full-time ☐ Part-time Times: Days of attendance: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday Does your child have an IEP? ☐ No ☐ Yes
Additional Considerations:	Please list any additional information you would like to share with your child's team regarding their educational experiences: ☐ N/A
Parent Concerns:	Do you have any current concerns related to your child's educational experiences? ☐ No ☐ Yes If yes, please explain:
Communication Skills	
Method(s) of Communication:	My child communicates through: ☐ Spoken language ☐ Sign language ☐ Verbal approximations ☐ AAC device ☐ PECS ☐ Gestures ☐ Other: My child prefers to communicate through: ☐ Spoken language ☐ Sign language ☐ Verbal approximations ☐ AAC device ☐ PECS ☐ Gestures ☐ Other:
Communication History:	When did your child do the following: Say their first word: Combine two words: How many words does your child currently use to communicate:

Strengths and Weaknesses:	What are your child's communication strengths? ☐ Indicating wants/needs ☐ Listening skills ☐ Requesting ☐ Labeling ☐ Articulation/intonation ☐ Echoics/vocal Imitation ☐ Asking/answering "wh" questions ☐ Conversational skills ☐ Other: What are your child's communication weaknesses? ☐ Indicating wants/needs ☐ Listening skills ☐ Requesting ☐ Labeling ☐ Articulation/intonation ☐ Echoics/vocal Imitation ☐ Asking/answering "wh" questions ☐ Conversational skills ☐ Other:
Parent Goals:	Please list any goals you have for your child's communication skills:

Social Interactions

Social Interactions:

How often does your child do the following:

	Never	Sometimes	Frequently	Always
Show you affection	☐	☐	☐	☐
Make eye contact	☐	☐	☐	☐
Respond to their name	☐	☐	☐	☐
Show interest in the behavior of others	☐	☐	☐	☐
Play/socialize with others				
Participate in social groups, clubs or sports teams	☐	☐	☐	☐

Preferred Social Interactions:	☐ Alone ☐ Parallel play ☐ Engaging with others ☐ Other
Strengths and Weaknesses:	What are your child's social strengths? What are your child's social weaknesses?
Additional Considerations:	Please list any additional information you would like to share with your child's team regarding their social skills:
Parent Goals:	Please list the goals you have for your child's social skills:
Play and Leisure	
Toy Play:	Does your child play appropriately with toys? ☐ No ☐ Yes If no, please explain:
Variation in Play:	Does your child show variation in their play routines? ☐ No ☐ Yes If no, please explain:
Preferences:	Please list your child's favorite items/activities/actions within each category: ☐ Shows/Movies: ☐ Sounds: ☐ Songs: ☐ Smells: ☐ Snacks: ☐ Tangible objects: ☐ Social interactions: ☐ Movement activities:

Strengths and Weaknesses:	What are your child's play skill <u>strengths</u>? What are your child's play skill <u>weaknesses</u>?
Additional Considerations:	Please list any additional information you would like to share with your child's team regarding their play skills:
Parent Goals:	Please list the goals you have for your child's play skills:

Self-Help

Please see the VB-MAPP Self-Help Checklist for a more detailed list of skills

Strengths and Weaknesses:	What are your child's self-help <u>strengths</u>? ☐ Dressing ☐ Bathing and grooming ☐ Feeding ☐ Toileting ☐ Other:	What are your child's self-help <u>weaknesses?</u> ☐ Dressing ☐ Bathing and grooming ☐ Feeding ☐ Toileting ☐ Other:
Medical Treatment:	Have the weaknesses indicated above been evaluated and/or treated by a medical professional: ☐ No ☐ Yes ☐ N/A Date of last follow-up: Name of the current or previous treating physician(s): Please attach the current treatment plan or most recent progress notes.	
Additional Considerations:	Please list any additional information you would like to share with your child's team regarding their self-help skills:	
Parent Goals:	Please list the goals you have for your child's self-help skills:	

Behavior	
Concerns:	Please indicate the behaviors you are currently concerned with: ☐ Response time ☐ Attention span ☐ Hyperactivity ☐ Restricted interests ☐ Repetitive behavior ☐ Stress/anxiety ☐ Biting (self or others) ☐ Hitting ☐ Kicking ☐ Elopement (running away) ☐ Food selectivity ☐ Food refusal ☐ Property destruction ☐ Self-injury ☐ Noncompliance ☐ Impulsivity ☐ Safety skills ☐ Other:
Medical Concerns:	Have any of these behaviors of concerns been addressed with a medical professional? ☐ No ☐ Yes If so, please list all current and providers who have addressed behavioral concerns (including psychiatrists, pediatricians, behavior analysts and specialty providers): Please attach the treatment plan or most recent progress notes.
Behavior Intervention Plan:	Has your child ever had a Behavior Intervention Plan (BIP)? ☐ No ☐ Yes If so, who developed it and when?
Behaviors of concern:	Behavior: Frequency: Duration: Triggers:

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Mandated Reporter Disclosure Form			
Patient's Name:		**Date of Birth:**	

This disclosure shall serve as a reminder to all patients and potential patients that staff members affiliated with Inspire Center for Autism are mandated reporters as deemed so by Arizona state rules, regulations, and laws. Such laws are in place to protect individuals from injury and should not be viewed as a means to harm parents/guardians or caretakers.

Being deemed a mandated reporter, requires by law, that any and all allegations, reports, and/or suspicions of child abuse, neglect, and/or maltreatment be reported to the appropriate identified governing body. Child Protective Services is the governing body identified in the state of Arizona regarding cases of child abuse, neglect, and maltreatment. Therefore, staff members of Inspire Center for Autism will report incidents mentioned above to the National Hotline for Child Protective Services.

It should be noted that the staff at Inspire Center for Autism shall only participate in CPS cases as required and requested by Child Protective Services. The staff at Inspire Center for Autism shall play no part in decisions made by Child Protective Services and should be viewed as a separate organization from Child Protective Services.

The patient and/or guardian shall sign a Mandated Reporter Disclosure Receipt Form that shall be kept in the patient's file as evidence that the information mentioned above has been provided to the patient and family.

I, _____, the legal guardian of _____ have read and received a copy of the Mandated Reporter Disclosure Form from Inspire Center for Autism.

Printed Name of Guardian:		**Date:**	
Signature:			

Patient Home Safety Checklist			
Patient's Name:		**Date of Birth:**	

The conditions listed below are deemed necessary to provide a safe and effective work environment in each patient's home. Please read each condition and initial where designated, to indicate your awareness of the listed expectation:

Smoking	Yes	No
Is this a smoke free home?		
If not, please indicate where smoking takes place:		

General Expectations	Initials
Fully functioning smoke alarms	
Fully functioning carbon dioxide alarms	
At least one smoke detector per level of the home	
At least one fire extinguisher on each level of the home	
Working plumbing	
Working cell phone service	
Proper illumination throughout the home	
Adequate, secure parking for Inspire Center for Autism staff during sessions	
Walkways are clear of clutter, debris and obstructions	
Absence of rodents and/or insects	
Bathrooms are regularly cleaned, free from soiled clothing and/or diapers	
Bathrooms are adequately supplied with necessary items (i.e., toilet paper, soap, hand towels)	
Stairs are free from clutter, debris and obstructions	
Handrails on the stairs are secure	

Designated Area for ABA Sessions	Initials
Floor space is available for session activities	
Workspace is available, including a table and chairs	
Therapy materials are stored in a secure location, where the patient is not able to access the materials outside of session time	
Adequate heat/air conditioning is provided, and proper ventilation is available	
Workspaces are regularly cleaned, vacuumed/swept and free of debris	
Inspire Center for Autism is not responsible for any damage to the work area caused by the patient	

Other Household Members	Initials

Siblings are not present in the work area, unless explicitly invited by an Inspire Center for Autism staff member	
Conflicts between family members that may occur during sessions are handled respectfully	
All household members maintain themselves in a presentable manner during work times	
No illegal activities on premises	
At least one parent/guardian or caregiver is present throughout session time	
Inspire Center for Autism will be notified regarding household members that have medical conditions or may pose a medical risk	

Animals	Yes	No	NA
Are there animals are in the home? If so, please list below.			
If so, are animals in the home, are they up to date on all recommended vaccines?			
If there are animals in the home, is there a history of aggressive behavior? If so, please list below.			
Animals: Aggressive behavior:			

Firearms	Yes	No	NA
Are there firearms located in the home?			
If so, are the firearms located in a gun safe or properly stored?			

I, _____, the legal guardian of _____ understand the need to adhere to the above conditions and understand that failure to do so may result in the immediate cancellation of services.

Printed Name of Guardian:		**Date:**	
Signature:			