**A picture containing text

Description automatically generated**

**CLIENT INTAKE PACKET**

Dear Parents/Caregiver,

Welcome to California Spectrum Services! We are grateful that you are interested in our program and we are excited to have the opportunity to serve your child, and your family. California Spectrum Services looks to provide quality, caring service to each child that is enrolled. At California Spectrum Services we believe that working together, as a team, to address the unique needs of your child and family will provide new avenues for growth and development. Our assessments and program designs are grounded in the science of applied behavior analysis. Instructional programs and supports are guided by data-based decision-making that focuses on the individual needs of the child. Our clinical supervisors design programs that are tailored to the individual needs of your child, utilizing evidence-based practices with the goal of improving the acquisition, fluency, maintenance, and generalization of skills necessary to navigate their individual journey.

**The first step in enrolling in our program is completing the necessary paperwork for your child. Please thoroughly fill out each page of our Client Intake Packet that is provided below to the best of your ability. 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.**

**Once you have completed the forms, you may submit them:**

* **via email,**
* **fax or**
* **in person to our office**

**In addition to the application packet, please attach all medical and/or educational documentation relating to your child’s diagnosis (e.g., Psychological Evaluation, IEP, IFSP, etc.) and a copy of your child’s insurance card (if applicable). We will be in contact with you to continue the intake process and schedule an interview and observation(s) to start the initial assessment. We can also arrange for you to provide the intake packet to one of our team members during your first initial assessment appointment.**

**Please do not hesitate to contact us should you have any questions or concerns during our scheduled business hours (Monday-Friday 8:30-5:00 pm).**

Thanks again for your interest in our program!

Sincerely,

***California Spectrum Services***

|  |  |
| --- | --- |
| Bakersfield Office (661) 634-0789  Fax (888) 886-4071  ABA Program (661) 634-0789 or (661) 556-0021  Early Start Program (661) 699-8154  EIBT Program (661) 699-8154 | Ventura Office (661) 634-0789  Fax (888) 886-4071  ABA Program (661) 634-0789 or (661) 556-0021  Early Start Program (661) 699-8154  EIBT Program (661) 699-8154 |

**CLIENT INTAKE PACKET**

|  |  |
| --- | --- |
| Today’s Date: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Services for: |  | ABA Program |  | Early Start |  | Early Intervention Behavior Training |

|  |  |  |  |
| --- | --- | --- | --- |
| Person completing this form: |  | Relationship to Client: |  |

|  |  |
| --- | --- |
| Reason for Referral: |  |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Client Legal Name: |  |  |  |
|  | First Name | Last Name | Middle Name |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of Birth: |  | Gender: |  | Male |  | Female |

|  |  |
| --- | --- |
| Home Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City: |  | State: |  | Zip: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Caregiver | Contact Number | | Email |
|  |  | Cell/Home/Work |  |
|  |  | Cell/Home/Work |  |
|  |  | Cell/Home/Work |  |

Preferred form of contact Home phone Cell phone Work phone Email

**Family Information:**

**Parent/Caregiver 1:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Relationship: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Address: |  | City: |  | State: |  | Zip: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Cell Phone: |  | Home Phone: |  |

|  |  |
| --- | --- |
| Email: |  |

|  |  |
| --- | --- |
| Occupation: |  |

**Parent/Caregiver 2:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Relationship: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Address: |  | City: |  | State: |  | Zip: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Cell Phone: |  | Home Phone: |  |

|  |  |
| --- | --- |
| Email: |  |

|  |  |
| --- | --- |
| Occupation: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Parents/Caregivers are: |  | Married |  | Divorced |  | Separated |  | Single |

|  |  |  |  |
| --- | --- | --- | --- |
| If divorced or separated, who has physical custody? |  | Is it full or joint? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Who has legal custody? |  | Is it full or joint? |  |

|  |  |
| --- | --- |
| Are there any legal or custody issues that we need to be aware of or that may impact services? |  |

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is this child your: |  | Biological Child |  | Stepchild |  | Adopted Child |  | Foster Child |

|  |  |
| --- | --- |
| Persons living in the home: |  |
|  |
|  |

|  |
| --- |
| Are there any cultural/spiritual factors that we should be aware of or that may impact services? |

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

|  |  |
| --- | --- |
| What is the primary language spoken in the home? |  |

|  |  |
| --- | --- |
| Does your family/your child speak any other language in the home? |  |

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

**Caregiver Medical Information:**

Pregnancy (Prenatal and Perinatal Information

|  |  |
| --- | --- |
| Did your baby (babies) have any health or medical problems at birth? |  |

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

Did you have gestational diabetes, high blood pressure, depression, or postpartum depression with your

pregnancy?

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

Describe the outstanding characteristics of each trimester:

|  |  |
| --- | --- |
| First Trimester: |  |
|  |
|  |
| Second Trimester: |  |
|  |
|  |
| Third Trimester: |  |
|  |
|  |

Do you have any health problems or medical conditions not related to pregnancy? (Hypertension, health issues, etc.)

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

List any medications, injections, taken for self or baby and dates taken:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication/Injection | | Self or Baby | Dates Taken |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

List any tests taken (e.g., Amniocentesis, Ultrasound):

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**Child Medical Information:**

Provide Developmental History:

|  |  |
| --- | --- |
| Physical: |  |
|  |
|  |
| Psychological |  |
|  |
|  |
| Social |  |
|  |
|  |
| Intellectual |  |
|  |
|  |
| Academic |  |
|  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is your child currently in good health? |  | Yes |  | No |

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

|  |  |
| --- | --- |
| Do you have concerns regarding your child’s hearing or vision? |  |

|  |  |
| --- | --- |
| If yes, please explain: |  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Current Primary Care Physician? |  | Phone: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Physician? |  | Phone: |  |

List of Diagnosis:

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis | DSM codes (office use) | Diagnosing Doctor | Date Diagnosed |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

Is your child taking any medications (please list):

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Purpose | Date Started |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Please list any allergies your child has: |  |

|  |  |
| --- | --- |
| List any medical restrictions to your child’s activities: |  |

|  |  |
| --- | --- |
| Please list any allergies your child has: |  |

|  |  |
| --- | --- |
| List any special dietary needs: |  |

|  |  |
| --- | --- |
| Other medical conditions/information: |  |

**Child Medical Treatment History:**

Please list any hospitalizations your child has had:

|  |  |  |
| --- | --- | --- |
| Reason for Hospitalization | Date Range | Outcome |
|  |  |  |
|  |  |  |
|  |  |  |

Please list any surgical procedures your child has had:

|  |  |  |
| --- | --- | --- |
| Surgical Procedure | Date | Outcome |
|  |  |  |
|  |  |  |
|  |  |  |

Please list current and/or past medical condition(s):

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Condition | Date Range | Provider | Response |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please list the medical treatment history for your immediate family:

|  |  |  |
| --- | --- | --- |
| Family Member/Relationship | Date/Date Range | Medical Treatment |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Additional Service Providers:**

|  |  |  |  |
| --- | --- | --- | --- |
| Regional Center Coordinator (if applicable) |  | Phone Number: |  |

**Other Providers** (Psychologist, Occupational Therapist, Physical Therapist, Speech, Psychiatrist, and/or Counselor)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Type of Service** | **Phone Number** | **Date Ranges Services Provided** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Educational History**

|  |  |  |  |
| --- | --- | --- | --- |
| School Name? |  | Receives Special Education? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is your child in school for a full day? |  | If not, how many hrs.? |  | Grade |  |

|  |  |
| --- | --- |
| Current Teacher(s): |  |

|  |  |
| --- | --- |
| Does your child’s teacher have concerns about him/her? |  |
|  | |

|  |  |
| --- | --- |
| List Special Ed. Services your child receives (IEP/BIP)? |  |
|  | |

Does/Did your child receive(d) Speech (SLP)/ Occupational Therapy (OT)/ Physical Therapy (PT)/Mental Health (Psychologist/Psychiatrist, Counseling services at school or outside of school?

|  |  |  |  |
| --- | --- | --- | --- |
| Service | How many  hours at school? | How many hours  outside of school? | Date Ranges |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Behavioral Health Treatment**

|  |
| --- |
| Has your child ever received Applied Behavior Analysis (ABA)? If yes, how long, and when was the last date of services? |
|  |
|  |
|  |
|  |
|  |

|  |  |  |
| --- | --- | --- |
| Treatment/Therapeutic Intervention | Date Range | Response |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Has your child received Applied Behavior Analysis (ABA) services in the past to address:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Behavior | | Intervention | Date | Outcome |
|  | Aggression |  |  |  |
|  | Self-Injury |  |  |  |
|  | Property Destruction |  |  |  |
|  | Tantrum |  |  |  |
|  | PICA |  |  |  |
|  | Other |  |  |  |

Has any member of your immediate family (i.e., spouse, children) received behavioral health treatment?

|  |  |  |  |
| --- | --- | --- | --- |
| Family Member/ Relationship | Treatment/Therapeutic  Intervention | Date Range | Outcome |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Background Information**

**Strengths:** Please list all of your child strengths such as eating with utensils, drawing, writing, computer, etc.

|  |
| --- |
|  |

**Main Concerns:** Please list any concerns the child may have at home or in the community.

This may include, but not limited to behaviors, communication, social skills and play skills. Additionally, provide any special accommodations that would help staffs to better support the child’s progress.

|  |
| --- |
|  |

**Other Comments:**

|  |
| --- |
|  |

**Communication**

|  |  |  |
| --- | --- | --- |
| **What is your child’s primary method of communication**: Check all that apply below and provide examples | | |
|  | **Gestures:** |  |
|  |  |
|  | **Spoken Words:** |  |
|  |  |
|  | **Word Approx.:** |  |
|  |  |
|  | **Sign Language:** |  |
|  |  |
|  | **Picture Icons:** |  |
|  |  |
|  | **Other:** |  |
|  |  |

**Social Play**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Does your child seek social interaction with:** |  | **Parents** |  | **Siblings** |  | **Other Adults** |  | **Peers** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Does your child play** |  | **Independently** |  | **Next to other children** |  | **By him/herself** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **What play skills does your child have?** |  | **With toys appropriately** |  | **Easy card games appropriately** |
|  |  | **Board Games** |  | **Takes Turns** |
|  |  | **Follows game rules** |  | **Keeps score** |

|  |
| --- |
| **Additional Comments:** |
|  |
|  |

**Behavior**

**List inappropriate behaviors that your child engages in:**

|  |  |  |  |
| --- | --- | --- | --- |
| Behavior | | Describe the behavior(s) - What does your child do? | How Often? For How Long? |
|  | Physical Aggression |  |  |
|  | Verbal Aggression |  |  |
|  | Self-Injury |  |  |
|  | Property Destruction |  |  |
|  | Tantrum |  |  |
|  | Eats inedible objects |  |  |
|  | Inappropriate sexual behaviors |  |  |
|  | Other |  |  |

**For each of the behaviors listed above provide the following information:**

|  |  |  |
| --- | --- | --- |
| Behavior | Triggers (antecedents)  (What happens right before the behavior?) | Consequences  (What do others do when or after child engages in behavior?) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Adaptive Living Concerns**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Toileting |  | Independent Play |  | Fine Motor |
|  | Eating |  | Social Play |  | Gross Motor |
|  | Dressing |  | Group Skills |  | Cooking |
|  | Brushing Teeth |  | Household Routines |  | Leisure Time |

|  |
| --- |
| **Additional Comments:** |
|  |
|  |

**Parent/Family Priorities & Preferences**

**Top three areas/goals you would like to see change for your child in the next 6 months:**

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |

**Community Resources**

Are you aware or have researched access to other community resources (i.e., support groups, social services, school-based services, other social supports)?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

Have you ever received community resources? If yes, please list below.

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Community Resource | Name of Provider | Date/Date Range | Outcome |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Possible Reinforcers**

Please list all or any preferences that your child has shown and put \* next to the ones that are highly preferred in each category. Be SPECIFIC as possible!!

FOOD: (snacks, candies, chocolate – please be specific; kind or brand names)

|  |
| --- |
|  |

TOYS: (games, stuff animals, etc.)

|  |
| --- |
|  |

PHYSICAL CONTACT: (tickles, hugs, kisses, clapping, back rubs, etc.)

|  |
| --- |
|  |

ACTIVITIES: (reading books, listen to music, etc.)

|  |
| --- |
|  |

OTHER: (any special preferences not mentioned)

|  |
| --- |
|  |

**Release of Consent for Information**

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*A separate Consent for Exchange of Information form must be completed for each individual or agency you wish for CSS to communicate with\***

* I understand that my records are protected by data practice laws and cannot be released without my consent unless otherwise allowed by law.
* I understand that only the information and records indicated below will be released or obtained.
* I understand that this consent does not authorize the recipient of the information or records to re-disclose the information or records to any other person or facility unless authorized by law.
* I understand that the information will only be used for the purposes indicated below.
* I understand that I may withdraw or modify this consent at any time but, that the revocation or modification will not affect any release of information that previously occurred.
* I understand that this consent with expire and no longer be valid **one year** from the date it was signed.
* I understand that the observation and/or assessment can take place in either setting.

**I Authorize:**

California Spectrum Services

4865 Truxtun Avenue

Bakersfield, CA 93309

(661) 634-0789

Name of Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To obtain records from or release records to:**

Name of Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of information released:**

\_\_\_Assessments or evaluations \_\_\_Educational records

\_\_\_Behavior reports \_\_\_Medical records

\_\_\_Program Data \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information may be shared in person or by mail. I also give permission to share information using the following methods:**

\_\_\_Phone \_\_\_Email

\_\_\_Fax \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature Date

Federal Law: “This information has been disclosed to you from records whose confidentiality is protected by Federal Law prohibits disclosing this material. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.”

NOTICE OF PRIVACY PRACTICES

FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520]

**Background**

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

**How the Rule Works**

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity’s obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

* Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR164.500(b)(1).
* A correctional institution that is a covered entity (e.g., that has a covered health

care provider component).

* A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

* How the covered entity may use and disclose protected health information about an individual.
* The individual’s rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
* The covered entity’s legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
* Whom individuals can contact for further information about the covered entity’s privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

* A covered entity must make its notice available to any person who asks for it.
* A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.
* Health Plans must also:
* Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
* Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
* Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
* Covered Direct Treatment Providers must also:
* Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual’s written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
* When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual’s first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
* In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
* Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider’s office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
* A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

* Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
* Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature Date

**Insurance Reimbursement Form**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Client’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY Insurance**

**Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_ F \_\_\_**

**Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_ F \_\_\_**

**Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Identification #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (full SSN of Sponsor for Tricare) Group/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spoke to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (office use only)**

**\**Please Provide us with a copy of the front and back of your insurance identification cards***

**SECONDARY Insurance (if applicable)**

**Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_ F \_\_\_**

**Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_ F \_\_\_**

**Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Identification #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (full SSN of Sponsor for Tricare) Group/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured’s Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spoke to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (office use only)**

**Insurance Verification (For Office Use Only)**

**Deductible: Individual. $\_\_\_\_\_\_\_/Fam.$\_\_\_\_\_\_ Amount Met: Individual. $\_\_\_\_\_\_\_/Fam.$\_\_\_\_\_\_**

**Co-Pay: $\_\_\_\_\_\_\_\_ Co-Insurance: \_\_\_\_\_\_\_\_\_% Lifetime Max: $\_\_\_\_\_\_\_\_\_\_**

***Does treatment need to be pre-certified*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Covered Dx Codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Assignment of Insurance Benefits**

I understand the confidentially of my records as protected by law.  Information about me/my child cannot be released without my consent.  I understand I may revoke this consent at any time.

I hereby give authorization for California Spectrum Services to contact and inform my primary and secondary (if applicable) insurance companies of all medical information included in treatment plans relating to all claims for benefits submitted on behalf of myself and/or dependents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized signature of Subscriber Date

**California Spectrum Services Financial Agreement- ABA**

New patients approved for ABA services are responsible for any and all charges not paid for by healthcare insurance payers (private or public). By signing this client agreement, you are acknowledging that you understand this condition of service and commit to promptly paying California Spectrum Services for the services we provide to you, our valued client. Following the receipt of your patient statement, we will contact you to make payment arrangements. We accept cash, personal checks, money orders and credit cards.

Each healthcare insurance payer has different guidelines for allowing coverage of ABA therapy. It is helpful if you let us know your healthcare payer when starting services so that we may find out if prior authorizations are needed. If your healthcare insurance payer is an insurance that we do not contract with, you are required to make self-pay arrangements for the usual and customary pricing of our services. We will provide you with a detailed invoice of services rendered on a monthly basis (if applicable).

My signature below signifies that I have read and understand this client agreement for California Spectrum Services for ABA services. I agree to the terms in this agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from services.

Please note that if you change insurance providers you must contact the office as soon as possible to avoid any lapse in services. We currently are contracted with the following insurances: Aetna, Anthem, Blue Cross Blue Shield, Kern Health Systems, MHN (Health Net).

**Contact**: Financial Coordinator

(661) 768-8167

Printed Name of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for completing the client intake packet.**

# **Please Include the following when returning/submitting the intake packet:**

* Copy of your child’s insurance card(s)
* Medical documentation pertaining to your child’s diagnosis (autism, intellectual disability, etc.)
  + - Psychological Evaluation
* Reports from other service providers (if applicable)
  + IEP, Speech therapy, school services, occupational therapy, etc.

**Please fill out the availability form so that the assessor can contact you with a date and time for the initial interview**:

**Note:** The initial interview only requires the parent/caregiver to be present unless otherwise specified by the assessor

**Mark Times and Days when you are available (Initial interview will take between 1-2 hours)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Available | Monday | Tuesday | Wednesday | Thursday | Friday |
| 8:00-10:00 |  |  |  |  |  |
| 10:00-12:00 |  |  |  |  |  |
| 1:00-3:00 |  |  |  |  |  |
| 3:00-5:00 |  |  |  |  |  |
| Other: |  |  |  |  |  |

Please don’t hesitate to contact us if you have any questions when completing the intake packet, or regarding the intake process.

Thanks again,

Sincerely,

California Spectrum Services

**Frequently Asked Questions**

**Q: What is the next step once I have submitted the intake packet?**

**A:** One of our team members will contact you to schedule the first assessment appointment.

**Q: How long will it take for a CSS team member to contact me once I have submitted the intake packet?**

**A**: We will call you within 5 business days of submitting the intake packet

**Q: How long will the assessment process take?**

**A:** After the intake packet is submitted, the initial interview and direct observation will be completed within 2- 4 weeks, depending on availability. After the interview and direct observation are completed it will take 2 weeks to complete the initial assessment report.

**Q: What happens once the assessment process it complete?**

**A:** Once the assessment is complete. We submit the treatment plan to the insurance/funding source and wait for the insurance/funding source to provide us with an authorization for treatment (It can take up to 2 weeks to receive authorization, depending on insurance), we will contact you once we receive the authorization.

**Q: When will ongoing ABA services start?**

**A:** Once an authorization for services has been approved, it may take up to 2-4 weeks to schedule the sessions for your child. In total, it can take up to 1-2 months for in-home services to get started (from the onset of the initial interview to the time your child gets scheduled).

**Q: How many hours and days will my child be scheduled for ongoing ABA services?**

**A:** The number of treatment hours depend on the recommendations made in the initial assessment. Your child may receive 2-6 hours of services per day, 4-6 days per week depending on treatment recommendations.

**Q: How long will my child be receiving ABA services?**

**A:** ABA services are voluntary. At the end of every six (6) months, a progress report will be submitted to insurance/funding source. The report will include your child’s progress towards his/her goals, new proposed goals, new treatment recommendations, and/or treatment hours recommendations. Continuation of ABA services will depend on client needs.