Standards and Policies for Unlimited ABA Sports LLC

Parent Compliance With Scheduling..

Parents are expected to adhere to the agreed-upon therapy sessions.

Any changes or cancelations should be communicated at least24 hours in advance, except for emergency cases.

Parents should provide a minimum of 20 therapy hours per week as recommended by the BCBA.

Standards and Policies for Unlimited ABA Sports LLC

Confidentiality & Privacy

All information shared during therapy sessions, assessments and evaluations will be kept strictly confidential.

Parents are expected to respect the privacies of other families and not disclose any information about other clients or their children.

Therapists and staff members will adhere to HIPAA regulations and maintain the strictest level of confidentiality.

Standards and Policies for Unlimited ABA Sports LLC

Communication & Collaboration

Parents are encouraged to actively participate in therapy process and collaborate with the BCBA and Therapists.

Open and honest communication between the parents, BCBA & therapists is essential for the success of the therapy sessions.

Parents should promptly notify the BCBA about any changes in the child's medical or psychological condition that would effect therapy.

Standards and Policies for Unlimited ABA Sports LLC

Grounds For Termination Of Services

Non-compliance with the therapy schedule without proper notification or repeated cancelations without valid resons.

Failure to provide a suitable environment for therapy sessions. Including a quiet and distraction-free environment.

Disruptive or disrespectful behavior towrds therapists or staff members.

Failure to follow the recommendations and strategies provided by the BCBA.

Nonpayment of fees or consistent late payments without prior arrangements.

Unlimited ABA Sports LLC
PO Box 326 Roselle, NJ 07203
(908) 884-9950
(908) 634-1690
Unlimitedaba@gmail.com
www.unlimitedaba@gmail.com

Sports Based ABA Training

INTAKE SCREENING FORM

Instructions:
Please complete and submit this screening form to schedule an appointment for an evaluation. You may submit this completed form to via of the communication methods up top.

The following is a comprehensive list of what will need to be provided. Numbers 1-5 can be sent to BCBA via email before the initial meeting or given to BCBA in person. Numbers 6-7 can be addressed during the initial meeting.

1. Your child's most recent IEP/BIP

2. Records of therapy (previous and current) for your child.

3. Diagnostic Information

4. Insurance Cards (if applicable)

5.Any documents related to services being received such as past intervention reports, or other relevant documents.

6. Any special accommodation your child may use, such as a chewy, weighted blanket, communication devices.

7. BCBA/BCaBCA will have additional questions regarding:
-Specific items your child is reinforced by
-Developmental history
-Sleep schedule
-Communication skills
-Adaptive skills (potty training)
-Problem Behaviors

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Please answer to the best of your ability. If you do not know any answers, your Unlimited ABA Supervisor will work with you closely to determine if it is relevant information necessary for treatment.

Child's Name: _____ **DOB:** _____

Sponsor ID/Insurance Subscriber ID: _____

Caregiver #1	Caregiver #2
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Email:	**Email:**

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Who Lives in the Home? (please include any pets so we can ensure proper employee placement for your home)

_____

_____

_____

_____

_____

CURRENT MEDICAL/SCHOOL INFORMATION

Primary Care Physician:

Name/Affiliation:_____

Address:_____

Phone:_____

School Information:

Name of school/teacher: _____

Address:_____

Phone Number:_____

Does your child have an active IEP? (YES / NO)

What grade level and placement setting does your child have at school? (i.e. EC Classroom, Gen. Education Setting, Resource)_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

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If permitted, ABA services can be provided in school for your child. This is based on district permissions and your child's specific needs. Are you looking to have school-based services in conjunction with home-based services for your child?
(YES / NO / Not Applicable)

Other Service Providers (Speech/OT/etc.):
Please include Facility, Names of Providers, and Contact Information

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Medical/Behavioral History:
Autism Diagnostic Info:
Diagnosing Date (month/year):

Diagnosing Provider (name/credentials):

Facility of Diagnosis (Name/State):

Level of Diagnosis (i.e. 1, 2, or 3):

Current Medications:

Allergies:

History of Seizures:

Any other Diagnoses (if none, please indicate):

Family History of Autism or related disorders (i.e. OCD, ADHD, etc.) If none, please indicate.

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BEHAVIOR: Does your child have a history of aggressive behavior that can cause harm to self or others? If so, please provide a brief overview (what it looks like, why it typically happens, and how often/how long the behavior can occur):

If you answered "Yes," have there been any specific behavior interventions previously implemented for your child? (YES / NO / Not Applicable)

MAIN AREAS OF CONCERN:
What is your child's main form of communication? Please circle all that may apply:
Verbally (with delays)
Verbally (age-appropriate)
Non-verbally (gestures only)
Communication Device
Picture Exchange (PECS)
Other:

Regarding receiving ABA services, what are the main areas of concern you would like to see an increase/decrease in with your child?
Ex: Communication, Behavior, Independence Skills, Social Skills, etc.

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Does your child have any sensory-related needs and/or aversions related to sights, smells, or sounds? (YES / NO)
If you answered yes, please explain:

Is there any other important information for Unlimited ABA to be aware of concerning your child that could impact ABA services? (YES / NO)
If you answered yes, please explain:

CHILD'S AVAILIBILITY FOR THERAPY SESSIONS:

Monday	Tuesday	Wednesday	Thursday	Friday

Please write your childs daily availibility in the correct box.

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PRIOR RELATED SERVICES

PLEASE LIST ALL PAST AND CURRENT THERAPIES YOUR CHILD HAS RECEIVED BY COMPLETING THE BOXES BELOW.

Service	Start/End Date (Month/Year)	How Often? (times per week/month)	Length of Sessions (In Minutes/hrs.)	Contact Info
Physical Therapy				
Speech				
Early Intervention				
Occupational Therapy				

Other (Please indicate):