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Getting to Know You

These forms do not obligate you or SOS Healthcare to ABA service. It is intended for the exchange of information only.

Today's Date ________________

Child Information

Child's Name _____________________________________ Date of Birth _________________

Age _________ Gender ____________

Address: ____

City: ________________ State: __________ Zip code: _________

Which county are you located? ______________________________________

Does your child have a medical diagnosis for Autism? □ Yes □ No

Legal Guardian Information

1. Legal Guardian's Name _____________________________

Relationship to Child ______________

Address: ____

City: ________________ State: __________ Zip code: _________

Phone (Home) _____________________ (Cell) _____________________

Email ____

Occupation _____________________________________ Work phone _______________

2. Legal Guardian's Name ______________________________

Relationship to Child ______________

Address: ____

City: _________________ State: __________ Zip code: _________

Phone (Home) _____________________ (Cell) _____________________

Email ____

Occupation ______________________________________ Work phone _______________

Other Information

How did you hear about us? ____

Please indicate your Case Worker or Early Interventionist's contact information

Name: __________________________________

Number: _______________________________________

Email: ____

Does your child have any of the follow funding that covers ABA therapy? Check all that apply.

□ Babynet

□ State PDD waiver

□ PDD waiver

□ Medicaid - please include Medicaid # ______________________________

□ Insurance: ____________________________________

Please list any insurance policies that your child has insurance through.

Primary Insurance Company ____________________________
Group #:____________________________
Insurance ID#: __________________________
Phone #: _________________________________
Name of Insured: ___________________________________
SSN: ____
Is ABA Therapy a covered service? ____________________________

Secondary Insurance Company ___________________________
Group #:___________________________
Insurance ID#: _________________________
Phone #: ________________________________
Name of Insured: __________________________________
SSN: _______________________________________
Is ABA Therapy a covered service? _________________________________

If ABA is covered please include a copy of the front and back of the insurance card, if ABA is not covered please include a letter from the insurance company stating that.

Has or does your child currently receive ABA services? □ Yes □ No

If yes, with whom were the services through and how long were services provided?
____
____

Does your child currently attend school? □ Yes □ No

Name of school ___________________________________ Teacher _____________________

Days/hours attending __________________________________ Grade/Placement _________

Parent/Guardian Name (Print): ____________________________________

Parent/Guardian Signature ______________________________________ Date ____________

Sponsor

Office Use Only

Date Received: _____________
Consultant Assigned To: ___________________________________
Date Assigned: _____________