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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 Work or EI's contact information

Name: _____

Number: _____

Email : _____

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

Babynet

Medicaid, SOS only excepts TEFRA Fee For Service Medicaid & Select Health
please include Medicaid # _____

Insurance: BCBS, TriCare (other insurances may be approved by a single case agreement)

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: _____