

# New Client Application

All fields marked with \* are required.

## PERSONAL INFORMATION

\*Name of Parent/Guardian

\*Parent/Guardian Phone Number

\*Parent/Guardian Email Address

\*Child's First Name

\*Child's Last Name

Child's Middle Name or Initial

\*Child's Gender ☐ Male ☐ Female

\*Client's Social Security Number

\*Address

\*City

\*State

\*Zip code

\*Services you are interested in

- ☐ ABA Therapy
- ☐ Social Skills Training
- ☐ Parent Coaching
- ☐ Telehealth Supervision
- ☐ RBT Supervision and Training

\*Please indicate other services you are interested in:

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**\*Please tell us a little about your child.**

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**\*What are your expectations for treatment?**

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**\*How did you find us?**

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**\*Place a ✓ on each day/time you are available.**

|         | Monday | Tuesday | Wednesday | Thursday | Friday |
|---------|--------|---------|-----------|----------|--------|
| 09:00AM |        |         |           |          |        |
| 10:00AM |        |         |           |          |        |
| 11:00AM |        |         |           |          |        |
| 12:00PM |        |         |           |          |        |
| 01:00PM |        |         |           |          |        |
| 02:00PM |        |         |           |          |        |
| 03:00PM |        |         |           |          |        |
| 04:00PM |        |         |           |          |        |
| 05:00PM |        |         |           |          |        |
| 06:00PM |        |         |           |          |        |



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**\*Does your child have a diagnosis of autism?**

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**\*Has your child ever received a psychological exam?**

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**Primary Medical Insurance Company**

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**Primary Medical Insurance Company**

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**Member ID or Policy Number**

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**Group Number**

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**Policy Holder Name**

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**Policy Holder Date Of Birth**

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**\*Subscriber's Social Security Number**

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**Additional Information**

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If the policy belongs to another patient, specify the relationship here. Or, specify any other relevant information.

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**Second Insurance Company**

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**Member ID or Policy Number**

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**Group Number**

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**Policy Holder Date Of Birth**

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**Additional Information**

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If the policy belongs to another patient, specify the relationship here. Or, specify any other relevant information.

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**Along with the filled out forms,**

- Please send the front and back of your insurance card.
- Please send your diagnosis report if you have one.
- Please send your Diagnostic evaluation/report (completed by a doctorate level clinician, Diagnosis date and by whom).
- Please send your MD prescription or signed coordination of care letter within the last 6 months.
- Please send any reports such as IEP, Speech, or ABA that you may have.
- Age of the first ABA treatment.

Please continue on the next page.



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**Do you have any secondary insurance including the Katie Beckett waiver, Deeming Waiver, and/or Medicaid?**

\*Please note per the GA Medicaid ASD manual: 801. Prior Approval for Adaptive Behavior Services (ABS) Prior Authorization (PA) is required for all Medicaid-covered ABS. Services without a PA will not be covered. A documented diagnosis of ASD must be established by a licensed physician or psychologist, or other licensed professional as designated by the Medical Composite Board prior to completing a PA for Behavioral Assessment or Treatment Services. As stated in 701, the diagnostic evaluation must use valid and reliable evaluation tools that conform to industry standards and include direct observation, parent/caregiver interviews, and standardized tools for the diagnosis of autism.

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**If so please send the following forms for a Medicaid authorization to be requested.**

- **Please upload your Diagnostic evaluation/report** (Autism Diagnostic Observation Schedule – Second Edition (ADOS-2), Autism Diagnostic Interview – Revised (ADI-R), the Diagnostic Interview for Social and Communication Disorders (DISCO), and/or other known evidence-based tools. The diagnosis must be made by a practitioner enabled by the OCGA practice acts to diagnose behavioral health/ intellectual/developmental conditions. An initial diagnosis should include the following-nConducted within the past three (3) years. • Minimum of two (2) assessment tools (1 clinician observational assessment, 1 caregiver assessment). • Summary of each individual assessment. • Include the date it was completed and include the tests administered with scores. • Include the evaluators name and credentials. A diagnostic re-evaluation to re-confirm diagnosis is required, at a minimum, every three (3) years and must be completed by a licensed professional. The re-evaluation must include, at a minimum, 1 clinician observational assessment. Children who are three (3) years of age or younger when they receive an initial diagnostic assessment, should be re-evaluated in one (1) to two (2) years. School psychoeducational assessments are not acceptable for diagnostic evaluations.)
- **Letter of Medical Necessity** ( This can be completed by the diagnosis physician or child's pediatrician and must be dated within the last 6 months).
- **Copy of the Medicaid card and/or Medicaid.**
- **Individualized Family Service Plan (if applicable).**
- **Individual Education Plan or IEP.**