Application for Services

Honey Bee THERAPY

Basic Information

Child's Full Name:	Nickname:

Date of Birth:	Height:	Weight:	Home Address:

Primary Contact #1:

Name:	
Phone Number:	
Email:	
Does this person have permission to pickup the client from the clinic?	[ ] Yes [ ] No

Primary Contact #2:

Name:	
Phone Number:	
Email:	
Does this person have permission to pickup the client from the clinic?	[ ] Yes [ ] No

Allergies and Severity (if none, please put N/A):

Pre-Existing Conditions and Other Medical Concerns (if none, please put N/A):

Additional Emergency Contact #1:

Name:	
Relation:	
Primary Phone:	
Does this person have permission to pickup the client from the clinic?	[ ] Yes [ ] No

Additional Emergency Contact #2:

Name:	
Relation:	
Primary Phone:	
Does this person have permission to pickup the client from the clinic?	[ ] Yes [ ] No

Funding Information

Funding Source (Check all that apply):

[ ] Insurance [ ] Autism Scholarship Program [ ] Private Pay [ ] Other: _____

Insurance Information (Skip if not using insurance):

Provider:	Card / Policy #:
Policy Card Holder:	Medicaid #:

What services are you interested in? (Check all that apply)

[ ] I am interesting in one-on-one sessions for my child
[ ] I am interesting in group sessions for my child

Treatment Information

Basic diagnostic information

What is your child's current diagnosis (if any)?	
At what age or date was your child diagnosed?	
Who was the diagnosing physician?	
Who is your child current physician?	

What medications your child is currently receiving; include the dosage amount:

Family Life

What is the child's current living arrangements?
[ ] Living with immediate family [ ] Living with extended family [ ] Living with foster family [ ] Living with adult siblings
[ ] Other: _____

Please include everyone in the household:

Name	Relationship with child	Age

Is there a history of developmental disorders in the family?
[ ] No [ ] Yes, please provide details: _____
Are there any current stressors or recent change in the family?
[ ] No [ ] Yes, please provide details: _____

Are there any cultural, language, religious restrictions we should be aware of?
[ ] No [ ] Yes, please provide details: _____

Education Information

Where does your child attend school?	
What is the type of school?	[ ] Public [ ] Private [ ] Homeschool [ ] Online [ ] Other
What grade is your child currently in?	
What days does your child attend school?	
What times does your child attend school?	
Is your child currently on an IEP?	[ ] No [ ] Yes, dates the IEP is effective:
Does your child receive any in-school services (OT, PT, Speech, APE, etc.)	[ ] No [ ] Yes, please provide details:

Service Information

Has your child received behavior therapy services previously?

[ ] No [ ] Yes, fill out the items below:

What was the name of the agency?	
How long were services rendered?	
Are you able to provide a previous treatment plan?	[ ] No [ ] Maybe [ ] Yes
Has there been a lapse in behavior therapy services?	[ ] No [ ] Yes, how long?

Besides behavior therapy and in-school services, does your child receive any other services?

[ ] No [ ] Yes, please provide details: _____

Behavioral Information

What are you child's strengths?

What are you child's areas of difficulty?

What are some items, tasks, or activities your child enjoys?

What are your top 5 goals for your child's treatment?

1	
2	
3	
4	
5	

As a parent, how would you like to contribute to your child's treatment?

What are some current behaviors of interest?

What is the duration and intensity (low, medium, high) of these behaviors?

What are the "triggers" for these behaviors?

How do you calm your child when these behaviors occur?

Scheduling Information

List your availability. Please note: The duration of the sessions is based on the recommendations given by the overseeing supervisor of your case.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday*	Sunday*

Be aware, we will accommodate your availability above wherever possible but in some cases this may not be possible. In these cases, alternative days, times, locations, and/or therapists may be assigned. *Weekend hours are limited.

Please provide additional information on any factors which may temporarily change your availability:

Please alert us as soon as possible when schedule changes occur.

Enrollment Disclosures

- For in-home services, an individual over the age of 18 who is responsible for the individual receiving services must be present in the home, but not necessarily involved in the session, while therapy is taking place. This can include a parent, grandparent, babysitter, Respite Care provider, sibling, or other trusted family member or family friend.

- Therapists are not permitted to transport individuals.

- Official documentation of diagnosis (i.e. diagnosis evaluation report) from the individual's medical physician must be provided before services can begin.

- Some insurance companies may have restrictions or coverage limitations on the type and/or amount of therapy which can be provided. During our funding verification process, we will receive this information but please check your insurance policy for more details.

- The enrollment process can take between 4 to 6 weeks to complete depending on insurance requirements, previous services, and availability.

PLEASE SEND COMPLETED APPLICATION TO:

oaschahightower@honeybeeaba.com

Print Reset Form