



Behavioral Intake Assessment (BIA) & Preliminary Brief Information

SECTION I: DEMOGRAPHIC INFORMATION

Participant's Name: _____ Home Phone: _____ - _____ - _____

Current School or Day Care or Day Habilitation attending: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Diagnosis: _____

Sponsor's SSN: _____ - _____ - _____ (For TRICARE only)

Mother's Name: _____ Cell Phone: _____ - _____ - _____

Email Address: _____ Work Phone: _____ - _____ - _____

Father's Name: _____ Cell Phone: _____ - _____ - _____

Email Address: _____ Work Phone: _____ - _____ - _____

SECTION 2: PARTICIPANT'S AVAILABILITY (must be filled out before first appointment)

Fill in time of day participant may be available for CBA services below:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

FOR OFFICE USE ONLY

First Actual Contact with Parent/Caregiver:

Date: _____ Time: _____ Init: _____ Notes: _____

Behavioral Intake Assessment Completed:

Date: _____ Time: _____ Init: _____ Notes: _____

First Appointment Scheduled:

Date: _____ Time: _____ Init: _____ Notes: _____

Attempts to Contact:

1. Date: _____ Time: _____ Init: _____ Notes: _____

2. Date: _____ Time: _____ Init: _____ Notes: _____

3. Date: _____ Time: _____ Init: _____ Notes: _____

4. If unable to contact in three attempts, Service Coordinator notified:

Date: _____ Time: _____ Init: _____ Notes: _____

If determined that our services do not meet parent / caregiver needs, refer to:

 Texas Association for Behavior Analysis: www.txaba.org**SECTION 3: FUNDING***Please select any funding sources you currently have:* 1. GENERAL REVENUE

Client ID/Case #:

Service Coordinator Name:

General Revenue Services Interested in Receiving from CBA, LLC:

 Applied Behavior Analysis Behavior Supports Speech Therapy 2. GOVERNMENT, MEDICAID, ICF/MR AND/OR OTHER AVAILABLE FUNDING SOURCES

List:

 3. TRICARE OR ECHO

Case Manager Name:

Phone: - -

DIAGNOSIS CODE (must have before service begin for TRICARE):

Referring Physician for ABA or who made the diagnosis:

 4. PRIVATE INSURANCE

List:

5. PRIVATE PAY

6. OTHER:

SECTION 4: SERVICES

Check the service the parent / caregiver is interested in.

- Type I: Behavior Supports (Components I, II, III)
- Type II: Applied Behavior Analysis (ABA)
- Type III: Community Supports (1:1 direct ABA therapy)
- Type IV: Specialized Intensive Parent Training (RAPID Skills Training)
- Type V: Other:

SECTION 5: PARTICIPANT INFORMATION

1. Current Treatment(s): (list or N/A)

2. Current Medication(s): (list or N/A)

3. Previous Treatment(s): (list or N/A)

4. Previous Medications: (list or N/A)

5. List Participant's current likes/interests:

6. Possible Behavioral Concerns:

Check if observed by the parent, school, facility, etc.

- | | | |
|--|--|--|
| <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Property Disruption | <input type="checkbox"/> Verbal Disruption |
| <input type="checkbox"/> Noncompliance | <input type="checkbox"/> Self-stimulation | <input type="checkbox"/> Self – Injury |
| <input type="checkbox"/> Toileting Problems | <input type="checkbox"/> Bizarre Speech | <input type="checkbox"/> Pica |
| <input type="checkbox"/> Feeding Problems | <input type="checkbox"/> Inappropriate Social Behavior | <input type="checkbox"/> Other |

List & Describe:

Of the behaviors selected above, list the top three of concern to the parent/caregiver:

1.

List # of times behavior occurs: Hourly | Daily | Weekly | Monthly

2.

List # of times behavior occurs: Hourly | Daily | Weekly | Monthly

3.

List # of times behavior occurs: Hourly | Daily | Weekly | Monthly