Autism Program Intake Form

Please complete the information below. Please either e-mail this form to lmaltbie@kidstlc.org or fax it to (913) 780-3387 (ATTN. Laci Maltbie).

GENERAL INFORMATION

Where did you hear about KidsTLC Autism Services? ☐ School ☐ KidsTLC Website ☐ Friend/Family

☐ Children's Mercy ☐ KU Med ☐ Children's Mercy ☐ Other: _____

What services are you interested in?

- ☐ Applied Behavior Analysis (ABA) Therapy
- ☐ Speech & Language Therapy
- ☐ Occupational Therapy

Child Name: _____ **DOB:** _____ **Age:** _____ **Gender**: _____

Race:

- ☐ Hispanic
- ☐ Non-Hispanic

School District: _____ **School Name:** _____

What type of educational setting does your child attend?

- ☐ Regular Ed/Inclusion
- ☐ Special Education (part of day)
- ☐ Special Education (full day)
- ☐ Private School
- ☐ Has a 1:1 aid at school

Parent:		**Parent:**	
Home Phone:		**Home Phone:**	
Cell Phone:		**Cell Phone:**	
Work Phone:		**Work Phone:**	
E-mail:		**E-mail:**	

Estimated Annual Household Income (2014): _____
Number of Household Members: _____ **Number of Household Members under age 18:** _____

Funding source (we are unable to accept Medicaid at this time):

☐ Private Pay ☐ Commercial Insurance (employer plan) ☐ Commercial Insurance (individual plan)

☐ Designated Donor Fund

INSURANCE INFORMATION

Please note: Verification of insurance coverage is only necessary if you plan to use insurance to fund services. If you plan to pay privately, please check that box above and leave the insurance information blank.

Does your child have a medical diagnosis? ☐ YES ☐ NO

If YES, what? Age diagnosed? Where?

DX_____ Age Diagnosed_____ Where _____

Primary Policy

Name of Policy Holder: _____

Address (if different from child): _____
City, State Zip Code

Relationship to child: _____

Primary Insurance Carrier: _____Insurance Phone #: _____

Case Manager: _____ Member ID #: _____

Insured Employer: _____ Insured Gender M or F

Insured SS #: _____

Secondary Policy

Name of Policy Holder: _____

Address (if different from child): _____
City, State Zip Code

Relationship to child: _____

Primary Insurance Carrier: _____Insurance Phone #: _____

Case Manager: _____ Member ID #: _____

Insured Employer: _____ Insured Gender M or F

Insured SS #: _____

Additional information may be needed in order to continue with the request for benefit information from your carrier. This may include, but is not limited to: 1) Copy of your child's diagnosis for a qualifying provider, 2) Copy of your current insurance card (front and back) and 3) Prescription for your PCP for the type of therapy you are requesting.

By completing and submitting this form, you are releasing any medical or other information necessary to process insurance claims once you become in enrolled in the KidsTLC autism program.

Please call (913) 324-3628 if you have additional questions about our services or enrollment process. We look forward to working with you and your child!!