

# BECOME BEST

*Behavioral & Educational Services & Training*

## ABA CLINIC

***Dedicated to the Science of  
Applied Behavior Analysis***

Dear Family,

Thank you for your interest in Applied Behavior Analysis (ABA) services provided by Become, Behavioral & Educational Services & Training, LLC. Please complete the enclosed Enrollment Application. The information provided will be utilized to design the BEST intake assessment and treatment possible. Please provide any additional information you feel would be useful in understanding more about your child. Once received, all information will be promptly reviewed and processed. You will be contacted shortly thereafter to discuss the process for getting started with ABA services. Completing this application does not ensure acceptance into Become BEST for services, however, if your child is accepted into the program, they will spend a 3-4 week period where strengths and need areas are identified, interventions are tested, and positive relationships are built to establish successful treatment.

When you have gathered and completed the documents, you can return them, together with a copy of your insurance card(s), front and back, via fax (712)-525-0036 or email: [admin@becomeaba.com](mailto:admin@becomeaba.com). Please include copies of any relevant medical records, such as all autism spectrum disorder diagnostic paperwork and medical scripts for ABA services. If you have copies of other evaluation reports, behavior plans, IEP's, etc. from the school district or other service providers, be sure to include them as well. Please feel free to call or text 712-746-7447 if you have any questions.

A complete application must include the following:

- ✓ Enrollment Application
- ✓ Insurance Coverage Information
- ✓ Copy of Front/Back of Insurance Card(s)
- ✓ Copy of Diagnostic Report/Referral for ABA Services
- ✓ Authorization(s) of Release/Request for Information

Thank you again for your interest in ABA services. We look forward to working with you.

BEST Regards,



Leah Clark, Ed.S, BCBA, LBA  
Founder/Owner  
School Psychologist  
Board Certified Behavior Analyst  
Licensed in IA

# BECOME BEST

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# ENROLLMENT APPLICATION

Today's Date \_\_\_\_\_

### Learner Information

Child's Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: M F

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

School District \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Is the home District aware of and involved in the application process?  Yes  No

Check if child has the following through the school:  IEP  504 Plan  SAT documentation

### Family Information

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

### Siblings

Name	Gender	Age	Relationship to Learner	Living at home?

Anyone else living at the same address

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**Medical Information**

Primary Physician \_\_\_\_\_ Clinic: \_\_\_\_\_

Does the child have Medical Diagnosis of Autism Spectrum Disorder?  YES  NO

Date of Medical Diagnosis \_\_\_\_\_ Name of the diagnosing Physician/Clinic \_\_\_\_\_

Do you have testing results/report from this physician  YES  NO

List all other diagnoses \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Medication/Vitamin/Supplement	Dosage	Time(s) Taken	Reason	Prescribing Physician

*Authorization for Release/Request of Information is included in application packet. Make copies & sign for the School District, Family Physician, Psychologists, Psychiatrists, etc.*

Does your child follow any special diets or have special dietary needs?  No  Yes If Yes, please explain:

Please list any other biomedical interventions:

**None known    Yes    If "Yes", please explain**

Is your child allergic to any medications?

Is your child allergic to any foods?

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Has your child ever had or been diagnosed with any of the following conditions?

	No	Yes		No	Yes
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vision or Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Tics/ Movement Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Stomach/Bowel Problems (ie: constipation, diarrhea, vomiting, reflux)	<input type="checkbox"/>	<input type="checkbox"/>	Genetic Disorders (e.g. Fragile X, Tuberous Sclerosis, Down syndrome, Rett Syndrome, Neurofibromatosis)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (environmental, seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Autism/ASD	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>
Head Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Heart Conditions/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mania / Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease (Asthma, other)	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Bladder/Genital Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Hormone/ Growth Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychiatric Illnesses	<input type="checkbox"/>	<input type="checkbox"/>

Has your child had any of the following evaluations?

Evaluation	If yes, results?				
	No	Yes	Unsure	Normal	Abnormal
Audiological Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Imaging (MRI, CT, or Ultrasound)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EEG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Evaluations, Procedures, Results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above were “**Abnormal**”, please explain:

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No	Yes	If “Yes”, provide date & explanation
Has your child ever been hospitalized?		
Has your child ever had any surgeries?		
Are immunizations up to date?	If “No”, explain	

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### Therapies and Services

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Please check other services that the child is *currently* receiving and list the number of hours per week.

Early Intervention Services- Hours/week \_\_\_\_\_

Occupational and/or Physical Therapy- Hours/week \_\_\_\_\_

ABA Therapy- Hours/week \_\_\_\_\_

Feeding Therapy- Hours/Week \_\_\_\_\_

Other (list) \_\_\_\_\_

Has your child previously received any of the above therapies or services?      Yes      No

### Communication

---

First showed signs of difficulties with communication:     No Concerns     Age 0-3     Age > 3

Current form of communication:     Vocal     Nonvocal     PECS     Sign Language     Other: \_\_\_\_\_

***Speech including (check all that apply):***

Single word

Conversation

Pointing

Two-word phrases

Leading to preferred items

Immediate Echolalia

Short Sentences

Gestures

***Frequency of communication:***

Communications frequently

Communicates with only certain individuals

Rarely communicates with others

How well does your child articulate words and sounds?

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### Daily Living Skills

Check areas in need of development:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Using Utensils | <input type="checkbox"/> Hygiene                        | <input type="checkbox"/> Follows Two Step Directions                         |
| <input type="checkbox"/> Eating         | <input type="checkbox"/> Point                          | <input type="checkbox"/> Community safety/survival                           |
| <input type="checkbox"/> Dressing Self  | <input type="checkbox"/> Touch                          | <input type="checkbox"/> Leisure/Play skills                                 |
| <input type="checkbox"/> Shoe Tying     | <input type="checkbox"/> Grasp                          | <input type="checkbox"/> Study/Work skills                                   |
| <input type="checkbox"/> Zipper         | <input type="checkbox"/> Reach                          | <input type="checkbox"/> Gross Motor Development<br>(walking, running, etc.) |
| <input type="checkbox"/> Buttons        | <input type="checkbox"/> Release                        |  |
| <input type="checkbox"/> Hand Washing   | <input type="checkbox"/> Follows One Step<br>Directions |  |
| <input type="checkbox"/> Tooth Brushing |   |  |

Are there any concerns regarding any of the following areas?

**No    Yes**

Responding to sound

Responding to touch

Responding to light

Emotional reactions/regulation

Difficulty with transitions

Understanding social cues (i.e., gestures, facial cues)

Inappropriate conversations

Inappropriate Behavior

Ritualistic Behavior

Repetitive Behavior (i.e., hand flapping, rocking, etc.)

Fixation (i.e., computers, certain TV shows, objects, toys, etc.)

Toileting

**Please explain any "Yes"**

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### Behaviors

Please check all the following behaviors that your child exhibits:

- |  |   |
|--|---|
| <input type="checkbox"/> Noncompliance with instructions     | <input type="checkbox"/> Stealing                                   |
| <input type="checkbox"/> Tantrums or loses temper easily     | <input type="checkbox"/> Lying                                      |
| <input type="checkbox"/> Verbally aggressive/argumentative   | <input type="checkbox"/> Fire setting                               |
| <input type="checkbox"/> Physically aggressive toward others | <input type="checkbox"/> Leaves room or building without permission |
| <input type="checkbox"/> Property destruction                | <input type="checkbox"/> Tics                                       |
| <input type="checkbox"/> Self-injury                         | <input type="checkbox"/> Hair-pulling                               |
| <input type="checkbox"/> Disruptive                          | <input type="checkbox"/> Phobia's/aversions                         |
| <input type="checkbox"/> Out-of-seat without permission      | <input type="checkbox"/> Complains about pain or discomfort         |
| <input type="checkbox"/> Pica                                |   |

Please describe any behavioral problems checked above, including what you think precedes the behavior and how other's typically respond:

Please indicate all possible availability for ABA Treatment

Time Frame	Monday	Tuesday	Wednesday	Thursday	Friday
8:30 a.m. - 12:30 p.m.					
12:30 p.m. - 4:00 p.m.					

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### **Happy, Relaxed, and Engaged**

Describe what it looks like for your child to be happy, relaxed, and engaged (i.e., laughing, smiling, shoulders down, breathing regulated, stimming, or not stimming, etc.)

What is your child's most preferred items & activities? Favorite characters/shows/toys/sounds etc.? How do they enjoy these items? Alone or with others? In a certain location?

Does your child enjoy proximity or being alone? High or low affect/energy? Physical interactions such as high fives, tickets, sensory input? Do they enjoy being asked questions? What are their interests or preferred topics of conversation?

What context is happening to reliably end your child's happy, relaxed, and engaged state?

### **Goals**

What are your top three treatment goals for your child?

(1)

(2)

(3)

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### INSURANCE COVERAGE INFORMATION

To process your request, please submit this form with the front and back copy of your insurance card, a copy of the diagnosis report and the referral for ABA services..

Learner's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

Full Address: \_\_\_\_\_

Please select funding sources you currently have:

\_\_\_\_ Private Pay    \_\_\_\_ Medicaid    \_\_\_\_ Private Insurance    \_\_\_\_ Other (Please Specify)

### FINANCIALLY RESPONSIBLE PERSON

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Full Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer Address: \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION *(Please include a copy of the front and back of your card)*

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M/F Insured SS# \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION *(Please include a copy of the front and back of your card)*

Plan Name: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M/F Insured SS# \_\_\_\_\_

The undersigned hereby acknowledges that the information contained in this application is accurate in all respects. I authorize the release of any medical information, by Become, Behavioral & Educational Training & Services, LLC or its agents, in order to process medical claims with my insurance company. I authorize a copy of this authorization to be used in place of the original and request payment of benefits either to myself or to the above provider who acquires assignment. I acknowledge that I am financially responsible for payment, including any unpaid deductible, co-pay or co-insurance balances, or amounts not covered by my insurance policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please be advised that benefit information provided to you from Become, B.E.S.T., LLC is not a guarantee of coverage or claim payment. Benefit information provided is subject to all contract limits and your insurance status on the date service was provided. Accumulated amounts may change as additional claims are processed.

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### Authorization of Release/Request of Information

*Two-Way Release*

\_\_\_\_\_  
Child's Full Name

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Date of Birth

#### Agencies/Programs Permitted to Release

Become, Behavioral & Educational Services & Training

Agency #1 Name

\_\_\_\_\_  
School Name

Leah Clark

Provider(s)

\_\_\_\_\_  
Administrator

1019 Jones St. Sioux City, IA 51105

\_\_\_\_\_  
Agency #1 Address

\_\_\_\_\_  
Address

712-746-7447

\_\_\_\_\_  
Agency #1 Phone Number

\_\_\_\_\_  
Phone Number

712-525-0036

\_\_\_\_\_  
Agency #1 Fax

\_\_\_\_\_  
Fax

#### The information that may be released includes:

- Physical Examination
- Birth Record
- Medical Examination
- Psychological Examination
- Psychosocial History
- IEP/IFSP

- Progress Notes
- Summary of Treatment to Date
- Discharge Summary
- After Care Plan
- Medication Record
- Education Record

I understand: 1) I have the right to withdraw my consent at any time, 2) I have the right to inspect and copy the information to be shared, 3) I am providing my consent voluntarily and I understand the information on this form.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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### Authorization of Release/Request of Information

*Two-Way Release*

\_\_\_\_\_  
Child's Full Name

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Date of Birth

#### Agencies/Programs Permitted to Release

Become, Behavioral & Educational Services & Training  
Agency #1 Name

\_\_\_\_\_  
**Primary Physician Office**

\_\_\_\_\_  
Leah Clark  
Provider(s)

\_\_\_\_\_  
Provider(s)

\_\_\_\_\_  
1019 Jones St. Sioux City, IA 51105

\_\_\_\_\_  
Agency #1 Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
712-746-7447

\_\_\_\_\_  
Agency #1 Phone

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
712-525-0036

\_\_\_\_\_  
Agency #1 Fax

\_\_\_\_\_  
Fax

#### The information that may be released includes:

- Physical Examination
- Birth Record
- Medical Examination
- Psychological Examination
- Psychosocial History
- MDT/IEP/IFSP

- Progress Notes
- Summary of Treatment to Date
- Discharge Summary
- After Care Plan
- Medication Record
- Education Record

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\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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### Authorization of Release/Request of Information

*Two-Way Release*

\_\_\_\_\_  
Child's Full Name

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Date of Birth

#### Agencies/Programs Permitted to Release

Become, Behavioral & Educational Services & Training

Agency #1 Name

\_\_\_\_\_  
Agency #2 Name

Leah Clark

Provider(s)

\_\_\_\_\_  
Provider(s)

1019 Jones St. Sioux City. IA 51105

Agency #1 Address

\_\_\_\_\_  
Agency #2 Address

712-746-7447

Agency #1 Phone Number

\_\_\_\_\_  
Agency #2 Phone Number

712-525-0036

Agency #1 Fax

\_\_\_\_\_  
Agency #2 Fax

#### The information that may be released includes:

- Physical Examination
- Birth Record
- Medical Examination
- Psychological Examination
- Psychosocial History
- IEP/IFSP

- Progress Notes
- Summary of Treatment to Date
- Discharge Summary
- After Care Plan
- Medication Record
- Education Record

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\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date