Access Family Services Application for ABA Services

Instructions: Please complete the following information and submit online. You can also download this form from our website and fill out on your computer and email or print/scan to austismservices@accessfamilyservices.com, or print and fax to 919-896-6443.

Date:
Referred by:

Client Information:

Last Name: Middle Initial: First Name:
DOB: Home Address:
Sex: m f Race (optional):
SSN:
County:

Contact Information:

Parent or Legal Guardian Contact 1:
Name: Relationship to client:
Phone (cell): Phone (home):
Email address:
Address (if different from client):
Maybe add?
Primary Language:

Parent or Legal Guardian Contact 2:
Name: Relationship to client:
Phone (cell): Phone (home):
Email address:
Address (if different from client):
Maybe add?
Primary Language:

Insurance Information:

Primary:
Company/Type:
Policy Holder Name: DOB:
Subscriber ID: Effective Date:

Secondary:
Company/Type:
Policy Holder Name: DOB:
Subscriber ID: Effective Date:

Reason for Referral/Primary Concerns about the Client:

During the intake process we will be requesting detailed information regarding your child's history, current needs, and caregiver concerns. Please identify your top three concerns that you would like addressed during the first 6 months of treatment.

1.

2.

3.

You will be hearing from us within 72 hours. At that time a member of Access Family Services will be requesting a copy of a signed diagnostic or psychological evaluation confirming a diagnosis of Autism Spectrum Disorder(F84.0).
