Intake Packet 2025

Dear Parents and Guardians,

Thank you for considering ABA therapy services from the **Brent Woodall Foundation for Exceptional Children (BWF).** For us to schedule any services, please complete all pages and provide all documents as noted in the attached checklist. We must receive a fully completed packet prior to scheduling an appointment.

Typical timeline for Starting ABA Services:
Once the Intake Packet & supporting documentation has been received, you will receive a phone call from us within 2 business days. At that time, we will discuss the next steps, the schedule of services, and answer any questions you may have. Our Billing Specialist will verify insurance benefits and communicate out of pocket costs. Your child's BCBA will email you to schedule initial assessment. If authorization is required, it could take 2-10 days to receive authorization to complete the assessment. When the assessment is completed, the BCBA will write the treatment plan and submit it to the insurance company for authorization. This authorization can again take 2-10 days to be approved. Once approved, ABA services will begin.

For questions or more information please call us at 972-756-9170, or contact the following directly:
Intake Packet & Scheduling: Nicki Scott, n.scott@woodallkids.org, 972-756-9170
Billing & Insurance: Tashar Fluker, t.fluker@woodallkids.org, 469-250-7775 direct

Please provide your completed Intake Packet and all documents by mail, email, fax or in person to:

Brent Woodall Foundation for Exceptional Children
ATTN: Nicki Scott
7801 Mesquite Bend Dr. Suite 105
Irving, Texas 75063

E-mail: n.scott@woodallkids.org
Fax: 214-614-4650

INTAKE TABLE OF CONTENTS AND DOCUMENT CHECKLIST

Please complete this intake packet and submit it with the additional documentation listed below.
If you need assistance completing the intake packet or if you have any questions, please contact Nicki Scott at 972-756-9170 or n.scott@woodallkids.org.

Ways to Submit Your Intake Packet:

- Email: Nicki Scott at n.scott@woodallkids.org
- Fax: 214-614-4650
- In person: 7801 Mesquite Bend Dr. Suite 105

INTAKE FORMS AND DOCUMENTS REQUIRED

Intake Information (page 3-6)
Medical Release & HIPAA Authorization (page 7)

Child's Recent Photo

Diagnostic Evaluation

- Comprehensive diagnostic assessment with an autism diagnosis (F84.0) is required to use insurance as a method of payment. If your child does not have a diagnosis but you suspect they have autism, we are happy to provide you with a list of physicians who can provide a comprehensive evaluation.

Assessments or Evaluations: this may include

- Cognitive testing
- ABA assessments
- Speech Therapy evaluations
- Occupational Therapy evaluations

School Documents (if previous/current Special Education Program or ECI Services): this may include

- Individualized Education Plan
- Independent Educational Evaluation
- Family Support Plan

Copy of Parent's Driver License

Insurance ID Card(s) (front & Back)

Please only send copies as original documents will not be returned.

Brent Woodall Foundation for Exceptional Children
INTAKE FORM
GENERAL AND CONTACT INFORMATION

Please check any BWF services you are interested in for your child

☐1:1 ABA ☐Social Skills Groups ☐Consultation ☐IEP Consultation

Child's First Name Last Name Middle

Preferred Name Date of Birth Age Gender

Social Security Number /Ethnicity

Address City St Zip Code

Parent/Guardian Full Name Relationship to Child

E-mail Phone Number Employer

Driver’s License # and State / Date of Birth

Address is the same as the Child’s above ☐

Address City St Zip Code

Parent/Guardian Full Name Relationship to Child

E-mail Phone Number Employer

Driver’s License # and State / Date of Birth

Address is the same as the Child’s above ☐

Address City St Zip Code

Child’s Insurance Plan Member ID# Group #

Subscriber’s Name Subscriber’s DOB

Is the child enrolled in any other plan? ☐ Yes ☐ No

If yes, please provide a copy of both insurance plan ID cards so the primary plan can be determined.

Child Resides with ☐Both Legal Parents ☐Mother ☐Father ☐Legal Guardian

If Guardian, what is the guardian’s Relationship to the child

Who is the Primary Caretaker of the child

Child’s Parents Are ☐Married to Each Other ☐Never Married ☐Separated ☐Divorced

Are there any legal issues involving the child (divorce, custody, lawsuits, etc.)? ☐Yes ☐No

If yes, please describe the custody arrangements pertaining to custody, educational and medical decision making, and attach any related court documents

Language(s) spoken by child Primary Language Spoken in Home

Family Religious or Spiritual Background

Please list all parents, siblings, relatives or others living in the child's primary residence

Name ___________________________________ Age _____ Relationship to Child ____________________

Name ___________________________________ Age _____ Relationship to Child ____________________

Name ___________________________________ Age _____ Relationship to Child ____________________

Name ___________________________________ Age _____ Relationship to Child ____________________

Name ___________________________________ Age _____ Relationship to Child ____________________

CHILD'S MEDICAL & DEVELOPMENTAL HISTORY

Referred by _______________________________________ Phone #____

Reason for Referral _________________________________ Primary Diagnoses _________________________________

Date of Diagnoses ________________ Diagnosing Physician ____

Please list any additional diagnosis ____

Are all recommended/required immunizations up to date? ☐Yes ☐No

Child's Current pediatrician ____ Phone # ___________________________

Are there any other physicians currently treating the child? ☐Yes ☐No

If Yes, please provide name of physician and type of treatment:____

Please check if the child has a history of:

☐ Bowel Problems
☐ Chewing Problems
☐ Drooling
☐ Ear Infections
☐ Headaches
☐ Hearing Problems
☐ None
☐ Hospitalizations
☐ Motor/Vocal Tics
☐ Seizures
☐ Sleep Difficulties
☐ Staring Episodes
☐ Surgeries
☐ Swallowing Difficulties
☐ Threatening harm to self/others
Vision Problems

Please provide details regarding any surgeries or hospitalizations

Previous hearing test results ☐ Normal ☐ Abnormal

Previous vision test results ☐ Normal ☐ Abnormal

Did child have any of these diseases? Chickenpox at age ____ Measles at age ____ Mumps at age ____

Was this child adopted? ☐Yes ☐No Length of pregnancy _____________ weeks Birth weight __________lbs.

Age when taken home __________________ Was there trauma associated with the birth? ☐ Yes ☐ No

If yes, please explain ____

Describe child as an infant/toddler, up to 24 months (e.g., cheerful, fussy, cuddly, withdrawn, etc.)

Age child began:	Early	Typical	Late	Not Present
Crawling				
Standing alone				
Walking alone				
Babbling				
Speaking first words				
Speaking short sentences				
Eating solids				
Self-feeding				
Using toilet when awake				

CHILD'S BEHAVIORAL INFORMATION

Information is used for assessment/evaluation and will not affect the child's eligibility for BWF services.

Please check any of the following behaviors the child displays:

☐ Aggressive behaviors ☐ Anxiety (control/transition/coping difficulties) ☐ Hyperactivity

☐ Self-injurious behaviors ☐ Self-stimulatory behaviors ☐ Eloping

For those checked, please explain:

Does the child:	Never	Seldom	Sometimes	Often	Always
Use gestures (bye-bye, pointing, etc.)					
Babble					
Use phrases to request					
Ask questions					
Play with toys appropriately/independently					
Play interactively w/siblings					
Play interactively w/peers					

Please tell us more about your child:

Child's most preferred toys, foods or activities

Child's eating habits, variety of foods accepted and independence with feeding

Child's sleeping patterns and routines

Child's strengths

Child's areas of concern

SCHOOL AND THERAPY INFORMATION

School ______________________________ School District ___________________________________ Grade __________

Briefly describe your child's school placement (self-contained, integrated, number of days and times the child attends)

Describe the child's academic performance____

Describe the child's Behavior in school ____

Therapy Services Provided by the School (hours per week)–(*please provide a copy of the current IEP)*

Speech Therapy ___Hrs/Week Occupational Therapy ___Hrs/Week Physical Therapy ___Hrs/Week

Other (include type and hours per week)____

Current and Past Private Therapy Providers NOT Provided by the School

(Please provide a copy of any evaluations and treatment plans associated with each therapy)

Therapy	Provider Name	Dates Attended	# Hrs. per Week
ABA			
Speech			
Occupational			
Physical			
Mental Health			
Feeding			
Other			

The Brent Woodall Foundation for Exceptional Children
MEDICAL INFORMATION AND RELEASE

Child's First Name Last Name ________________ DOB Height Weight lbs.

Diet Specifications Allergies ________

Child's Communication ☐ Verbal ☐ Minimally Verbal ☐ Non-verbal ☐ Gestural ☐ AAC system

Behavioral Concerns ☐ Aggression to others ☐ Self-injury ☐ Other________________________________

Are all recommended/required immunizations up-to-date? ☐ Yes ☐ No

Child's Current Pediatrician ____Phone # ___________________

Are there any other physicians currently treating the child? ☐ Yes ☐ No

If yes, please provide name of physician and type of treatment ____

Please list all current prescriptions and over the counter medications, and vitamins/supplements:
Please include Medication/Vitamin/Supplement, Dosage, Purpose, & Prescribing Physician

Parent/Guardian Name ____ Email ________________________________

Please provide primary contact number for: Mom _______________________ Dad __________________________

Emergency Contacts – Please include 2 emergency contacts other than the child's parents.

1. Name ____________________________ Relationship _____________________ Phone ______________________

2. Name ____________________________ Relationship _____________________ Phone ______________________

I give permission to the Brent Woodall Foundation to administer First Aid/CPR to the child if an emergency situation arises and to provide necessary information to First Responders.

Parent/Legal Guardian Signature **Parent/Legal Guardian Name**

HIPPA Release

I hereby authorize the Brent Woodall Foundation to release and discuss the child's confidential information with the following (please list name, phone#, and if a family/friend the relationship):

3rd Party Funding Sources (Insurance Companies, Health Plans and Grant Organizations)

Referring Physician ____

Child's School ____

Other Providers ____

Family/Friends ____

I do not give my permission to release information to anyone other than the 3rd Party Funding Sources.

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization and understand that prior actions taken in reliance on this authorization by entities that had permission to access this health information will not be affected.

Parent/Legal Guardian Name **Relationship to Child**

Parent/Legal Guardian Signature **Date**