

Please check the box next to the program/service you are interested in:

CLIENT NAME: _____

Intensive Behavioral Intervention (IBI):

Service description: Child receives individual instruction designed to remediate the symptoms of autism spectrum disorder. Training support for parents is designed according to the child and family's needs.

Time commitment: Child must be available Monday through Friday, every day for 2 three hour shifts for a minimum of 30 hours per week. We are only able to work around a child's schedule who still requires naps. Additional weekday and weekend hours are available after the initial 30 hours are scheduled.

Length of service: Length of service is typically 2 – 4 years

Where the service takes place: Service occurs in the child's home; caregiver must be present

Family Centered Behavioral Intervention (FCBI):

Service description: Board Certified Behavior Analysts teach parents to generate solutions to problem behavior inside of difficult routines. Parents learn functional assessment techniques and are gradually introduced to making independent treatment recommendations

Time commitment: Five hours of service; two 2.5-hour blocks of time each week

Length of service: Services range from 6 months to 2 years depending on scope of family needs – we include all members of family in treatment planning.

Where the service takes place: Service occurs in the child's home; caregiver must be present

Behavioral Consulting:

Service description: Licensed Psychologist/Board Certified Behavior Analyst conduct *functional analyses* and design *individualized* program recommendations for the child or adult with challenging behavior and skills deficits associated with a wide variety of diagnoses. Parents, PCA's, teachers, paraprofessionals, interdisciplinary team members, and vocational staff are trained to implement effective behavioral strategies to address behaviors of concern.

Time commitment: Services begin with weekly assessment/training meetings fading to monthly meetings. Duration of clinical involvement may range from 6 months to several years depending on the needs of the individual and family or support personnel.

Length of service: Duration of clinical involvement may range from 6 months to several years depending on the needs of the individual and family or support personnel.

Where the service takes place: Consulting is provided at home (including foster home or waiver home), school, work, or community settings as authorized by the applicable funding sources.

Other Professional Services:

Workshops, program evaluation, key note address, conference presentations, non-clinical consultation, etc. Workshops and other training sessions can be developed on specific topics and tailored for specific audiences.

Addresses, brief presentations (two hours or less), and informational sessions on current topics in behavior analysis, in-home family behavioral supports, autism, and other areas of interest for your parent group, professional association, or company lunch break seminars.

Program evaluations, expert witness opinions, and a wide variety of other professional services can be provided. Let us know what you need and we will serve you ourselves or direct you to an appropriate source.

Family/Client Information

Contact name: _____ Relationship to client: _____ Today's date: _____

Client name: _____ Client date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number(s): _____ Email: _____

Diagnosis (if known): _____

Behavioral issues (type and frequency):

Behaviors of Concern (check all that apply)	SEVERITY 1 – 5 (See rating scale to the right)	SEVERITY SCALE (consider all behavior together when rating your need for service)
Aggression to others (A)		<i>1 = Occurs weekly; can be redirected if adult intervenes</i>
Self-Injury (S)		<i>2 = Occurs a couple times a week; can be redirected with adult intervention</i>
Pica (P)		<i>3 = Occurs daily; with adult intervention can be redirected</i>
Property destruction (PD)		<i>4 = Occurs daily, difficult to redirect even with adult intervention</i>
Non-compliance (PD)		<i>5 = Injuries occur to child or others; difficult to intervene</i>
Tantrums (T)		
Other (describe):		

Is your family in crisis? If yes, what is the nature of the crisis?

Family information (# of parents, siblings and others living at home)

Location where service is needed (check appropriate location(s):

Home:

School: Has school administration approved services from an outside provider? _____

Has the school agreed to pay for services from an outside provider? _____

Work site: Has work site administration approved services from an outside provider? _____

Has the work site agreed to pay for services from an outside provider? _____



Behavioral Dimensions Intake Packet

Payment/Funding/Insurance Information

Primary Insurance Provider: _____ Policy Number: _____

Primary Insurance Phone Number: _____

Secondary Insurance Provider: _____ Policy Number: _____

Secondary Insurance Phone Number: _____

Medical Assistance/TEFRA

Medical Assistance Number: _____

Waiver (DD, CADI, TBI): _____

School contract: _____

Our services typically start in your family’s home. Please check the hours your child/family are available for services (please check all that apply – we will be able to serve you more quickly the more availability you have):

- 8:00am -10:00am 10:00am - 12:00pm 12:00pm - 2:00pm 2:00pm - 4:00pm
- 4:00pm - 6: 00pm *6:00pm – 8:00pm

*Please note that Behavioral Consulting is not available during these times.

Thank you for your interest in services with Behavioral Dimensions. Please click the submit button to email this form to our office:

This form can also be printed and mailed or faxed to our office at the address below:

Behavioral Dimensions, Inc.
 7010 Highway 7
 St. Louis Park, MN 55426
 Phone: 952-814-0207
 Fax: 952-938-8838
 Email: office@behavioraldimensions.com

Intake Disclosure: We appreciate your interest in Behavioral Dimensions, Inc. Please note that we will only retain your intake form information for one year after we have received it. If you have previously submitted an intake form and your wait has been longer than 1 year from the date you submitted your form, please re-submit your information on the intake form.

For office use only:

LP contacted: _____ Date of contact: _____

LP Response: _____ Date of response: _____

LP Response: _____ Date of response: _____

LP Response: _____ Date of response: _____

Family contacted: _____ Type of contact: _____ Date of contact: _____