OFFICE USE ONLY:

Date Received:

REQUEST FOR SERVICES

Child's Full Name:_____ Date:_____

Child's DOB:_____ Child's Age:_____

1). Parent Name(s):_____

2). Address:_____

3). Contact Information:

Mother: Phone: _____ E-mail:_____

Father: Phone: _____ E-mail:_____

Preferred method of contact: ☐ Phone ☐ E-mail

4). Is your child receiving services from any other organization? ☐ Yes ☐ No

If yes, please list services and organization:

Service/Therapy	Provider	Hours per week

5). Please indicate the services that you are interested in receiving from us:

☐ Academic assessment only

☐ In-home ABA services

☐ Behavior consultation/management

☐ Early intervention services

☐ Parent education and training only

☐ Adaptive skills (self-help, toilet training etc.)

Client intials _____

6). For behavior management services, please describe the problem behaviors:

_____

_____

_____

7). Funding information:

☐ Private pay

☐ School district _____

☐ Medical insurance _____

☐ Other: _____

8). Are you or your spouse active duty military? ☐ Yes ☐ No

Please mail or fax the completed request form to:

Interact Behavior Consulting
2340 Powell Street, Suite 347
Emeryville, CA 94608
FAX: (855) 249-5322

Thank you for your interest in Interact Behavior Consulting services. Once we receive your request, we will be contacting you to discuss the availability of services. Please note that some services might not be available at the time of request and your child may be placed on a waiting list.

Office use only:

Attempts to Contact:
1. Date: _____ Time: _____ Notes: _____
2. Date: _____ Time: _____ Notes: _____
3. Date: _____ Time: _____ Notes: _____
4. If unable to contact in three attempts, Case Manager notified:
Date: _____ Time: _____ Notes: _____

☐ Wait listed for services

☐ Approved for intake—Initial consultation date and time: ___ /___ /____ ____: ____ PM/AM

Approved by: _____

Client intials _____