Welcome Packet

March 9, 2021

Wilmington

510 Philadelphia Pike
Wilmington, DE 19809

Phone: (302) 575-9702

Clinical Manager:
Samantha Donohue, BCBA

Serving Wilmington, Elsmere, Claymont, Greenville, Newark

Middletown

200 Cleaver Farm Rd
Middletown , DE 19709

Phone: (302) 449-2011

Clinical Manager:
Amanda Shronk, BCBA

Serving Middletown, Bear, Townsend, Smyrna, Odessa, Elkton

Milford

1010-1012 Mattlind Way
Milford, DE 199963

Phone: (302) 503-3120

Clinical Manager:
Clara Tiedemann, BCBA

Serving Dover, Milford, Georgetown, Magnolia, Milford, Lewis

General Intake Application

Dear Parents and Guardians,

Thank you for choosing BrightBloom Centers. We offer a safe and enriching environment for children to reach their full learning potentials. Partnering with families and schools, our compassionate behavioral specialists use a science-based approach called Applied Behavioral Analysis (ABA) therapy, an individualized treatment program based on proven theories of learning and behavior.

Studies have shown that intensive intervention is most effective with ABA therapy. Children come into our center for up to six sessions per week. Each session is typically two to four hours. We strongly encourage a minimum of 20-25 hours of direct therapy per week to start; however, based on your child's needs and parent goals, therapy hours may increase to 30 hours a week.

Enclosed is a General Intake Application, the first step towards starting services with BrightBloom. Please use the checklist to ensure we have all the information necessary to understand your insurance benefits, family history, and therapy needs.

Following the receipt of the intake application and supporting diagnostic information, we will add your family to a waiting list. Wait times vary by location and preferred session time. Please visit the FAQ page on our website, www.brightbloom.com, for more information.

Please direct any questions to Josefien O'Reagan, Intake Coordinator at joregan@brightbloom.com.

We look forward to working with you.

Sincerely,
BrightBloom Centers

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Documentation Checklist

- ☐ Intake form (attached)
- ☐ Copy of all current medical insurance cards (front and back)
- ☐ Most recent IEP/IFSP
- ☐ Diagnostic evaluation report (school and/or clinical)
- ☐ ABA prescription from a medical doctor (MD)
- ☐ Letter of Medical Necessity (Medicaid clients only)
- ☐ Most recent ST/PT/OT evaluations

ABA Therapy Registration Application

Client Information

Client Name: ____ DOB: __________________________

Male ____________________ Female ____________________ SSN: ____________________________

Mother / Guardian Name: ____

Mother Primary Phone #: ___________________ Mother Email Address: ________________________

Mailing Address: ____

City: ____ State: ________ Zip: _____________

Father/ Guardian Name: ____

Father Primary Phone #: ______________________ Father Email Address: ______________________

Mailing Address: ____

City: ____ State: ________ Zip: _____________

Referral Source: ____

Emergency Contact Name: _____________________________ Relationship: ______________________

Phone #: _______________________ Email Address: ____

Insurance Information

Primary Insurance Provider: _____________________ Member ID No.: ___________________________

Subscriber Name: _______________________________ Subscriber DOB: _____ /_____ /___________

Guarantor Name: ___________________________ Guarantor SSN: _______________________________

Secondary Insurance Provider: ___________________ Member ID No.: ___________________________

Subscriber Name: _______________________________ Subscriber DOB: _____ /_____ /___________

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Medical Information

Primary Diagnosis: _____________________________ Date of Diagnosis: _____ /_____ /___________

Name of Diagnosing Doctor: ___________________________________ NPI: ______________________

Practice Name: ____

Phone #: ___________________________________ Fax #: _______________________________________

Is your child a current patient of the diagnosing doctor?: Yes __________ No ___________

Any additional diagnoses? If so, please list:

____

____

____

____

School Information

Is your child currently enrolled in school? Yes __________ No ___________

If yes, please complete the following:

School Name: ____

County: ____

Grade: _________ Pre-K: _________ Teacher's Name: ___________________________________

Teacher's Email Address: ____

Classroom Setting:

- ☐ Self-contained classroom
- ☐ Resource room (partially mainstreamed)
- ☐ Regular classroom

Other: ____

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School Therapies

☐ SLP: ___________ times per week for ___________; (Done at UD)

☐ OT: ____________ times per week ___________;

☐ PT: ____________ times per week ___________;

ABA History: Has your child previously received ABA therapy services? Yes _____ No ______

If yes, where did he/she previously receive services and how often:

____

____

____

____

____

____

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Has your child previously received ABA therapy services? Yes _____ No ______

If yes, where did he/she previously receive services and how often:

____

____

____

____

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Medical History

Please list all medications you child is currently taking, including over the counter medications:

Medication	Purpose	Date	Began

Please list any known allergies or diet restrictions:

____

____

____

Scheduling and Routines

To aid us in creating a therapy schedule for your child, please write out your typical weekly schedule and availability for services. Please include all of your availability for services and indicate what your preferred hours of service would be.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Location Preferences:

☐ Home ☐ Center ☐ School

Please state the expectations/goals that you have for your child while engaging in an ABA program:

____

____

____

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Please select all of the following behaviors of concerns which apply:

☐ Self-injurious ☐ Destructive behavior ☐ Aggressive behavior

☐ Elopement ☐ Communication skills ☐ Socialization skills

☐ Self-stimulatory behavior ☐ Tantrum behavior ☐ Verbal Outbursts

☐ Delayed general development skills (ex: imitation, identifying objects, sharing skills)

How often do these behaviors occur?

____

____

Current interventions used to address these behaviors?

____

____

Primary method of communication

☐ Vocal Primary Language: ____

☐ PECS/Picture Exchange

☐ American Sign Language

☐ Other: ____

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

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