INTAKE

DATE:	WHO CAN WE THANK FOR YOUR REFERRAL?	
IS THIS A NEW APPLICATION?		

IS THIS A DEEMING WAIVER RENEWAL?	Y		N		DATE DUE:				
IS APPLICANT A US CITIZEN?	Y		N		ARE PARENTS US CITIZENS?	Y		N	
DOES ANYONE IN THE HOUSEHOLD HAVE A GREEN CARD? ATTACH COPY						Y		N	
PLEASE PROVIDE DOCUMENTATION REGARDING ALL QUESTIONS ABOVE. AND SEND US A COPY OF ANY CORRESPONDENCE YOU HAVE RECEIVED FROM KATIE BECKETT.									

APPLICANT		
NAME:	NICKNAME:	GENDER:
DATE OF BIRTH:	PLACE OF BIRTH (CITY, STATE):	
STREET ADDRESS:	MEDICAID NUMBER IF APPLICABLE:	
CITY, STATE, ZIP:	SOCIAL SECURITY NUMBER:	
COUNTY OF RESIDENCE:		

PARENT INFORMATION	
PARENT #1 NAME:	PARENT #2 NAME:
MOBILE #:	MOBILE # :
EMAIL ADDRESS:	EMAIL ADDRESS:
EMPLOYER:	EMPLOYER:
EMPLOYER STREET ADDRESS:	EMPLOYER STREET ADDRESS:
EMPLOYER CITY, STATE, ZIP:	EMPLOYER CITY, STATE, ZIP:
EMPLOYER PHONE:	EMPLOYER PHONE:
SALARY/HOURLY?	SALARY/HOURLY?
HOW OFTEN PAID:	HOW OFTEN PAID:
DATE OF BIRTH:	DATE OF BIRTH:
Which Parent Will Be Signing the Paperwork?	

PLEASE LIST ALL OF APPLICANT'S SIBLINGS WHO ARE < 18 YEARS OF AGE & LIVE WITH YOU								
CHILD FIRST NAME	LAST NAME	GENDER	BIRTHDAY	US CITIZEN?	Y		N	

PRIMARY CARE PHYSICIAN/PEDIATRICIAN	
PRIMARY DOCTORS NAME – MUST BE AN MD:	
PRIMARY DR. PRACTICE NAME:	
STREET ADDRESS:	CITY, STATE, ZIP:
PHONE:	

EMPLOYER AND INSURANCE INFORMATION	
DOES ANYONE IN YOUR FAMILY HAVE INSURANCE	
COMPANY INSURED PARENT WORKS FOR	
NAME OF PARENT WHO IS INSURED	
*SS OF PARENT WHO IS INSURED – MUST HAVE	
ADDRESS OF EMPLOYER	
PHONE NUMBER OF EMPLOYER	
NAME OF INSURANCE COMPANY	
INSURANCE ID NUMBER	
INSURANCE POLICY EFFECTIVE DATE	
INSURANCE ADDRESS	
INSURANCE PHONE NUMBER	

INTAKE

PLEASE LIST ANY ACCOUNT THAT IS IN THE CHILD/APPLICANT'S NAME OR SSN		
TYPE OF ACCOUNT	**CURRENT AMOUNT IN ACCOUNT**	**BANKING INSTITUTION OR TRUST**

PLEASE LIST ANY SPECIALISTS THAT CHILD SEES	
SPECIALIST DR NAME:	**PHONE:**
STREET ADDRESS:	**CITY, STATE, ZIP:**
DOCTORS SPECIALTY:	**REASON:**
SPECIALIST DR NAME:	**PHONE:**
STREET ADDRESS:	**CITY, STATE, ZIP:**
DATE FIRST SAW APPLICANT:	**DATE LAST SAW APPLICANT:**
DOCTORS SPECIALTY:	**REASON:**
SPECIALIST DR NAME:	**PHONE:**
STREET ADDRESS:	**CITY, STATE, ZIP:**
DATE FIRST SAW APPLICANT:	**DATE LAST SAW APPLICANT:**
DOCTORS SPECIALTY:	**REASON:**

PLEASE LIST ONLY **CURRENT** THERAPY THAT CHILD PARTICIPATES IN *RIGHT NOW*		
THERAPY TYPE	**SEES THEM HOW MANY TIMES PER WEEK**	**PROVIDER**

LIST ALL INFORMATION REGARDING HOSPITALIZATIONS/SURGERIES THAT CHILD HAS HAD			
DATE SEEN OR ADMITTED	**DATE DISCHARGED**	**REASON SEEN/HOSPITALIZED**	**DOCTOR**

PLEASE NOTE THE PROGRAM THAT APPLICANT PARTICIPATES IN *RIGHT NOW*			
PROGRAM	**DATE STARTED**	**HOURS PER DAY**	**DAYS PER WEEK**
IEP			
BABIES CAN'T WAIT (IFSP)			
PUBLIC SCHOOL (IEP)			
PRIVATE SCHOOL			
OTHER			

PLEASE LIST ANY **PRESCRIBED** MEDICATION THAT CHILD TAKES EVERY DAY (IF NO ROOM ADD EXTRA SHEET)				
NAME OF MEDICATION	**DOSAGE**	**ROUTE**	**TIME OF DAY GIVEN**	**REASON**

INTAKE

PLEASE LIST ANY OVER-THE-COUNTER MEDICATION THAT CHILD TAKES REGULARLY				
NAME OF MEDICATION	**DOSAGE**	**ROUTE**	**TIME OF DAY GIVEN**	**REASON**

PLEASE LIST ANY CURRENT OR PAST CARDIOLOGICAL PROBLEMS CHILD HAS HAD					
CONDITION	**DATE OF DIAGNOSIS**	**DATE RESOLVED**	**CONDITION**	**DATE OF DIAGNOSIS**	**DATE RESOLVED**
PATENT DUCTUS ARTERIOSIS			**HEART MURMUR**		
CONGESTIVE HEART FAILURE			**ATRIAL SEPTAL DEFECT**		
ADDITIONAL COMMENTS:					

NEUROLOGY AND RELATED PROBLEMS			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
ADAPTIVE FUNCTIONING		**ADD/ADHD**	
ATTENTION PROBLEMS		**BIRTH COMPLICATIONS**	
AUTISM		**DYSPHAGIA**	
CEREBRAL PALSY		**COGNITIVE IMPAIRMENT**	
DYSPHSIA		**LEARNING DISABILITIES**	
DEVELOPMENTAL DELAY		**MOOD DISORDER**	
INTRACRANIAL HEMORRHAGE		**MOUTHS INEDIBLE OBJ.**	
MEDICALLY FRAGILE		**OCD**	
MOOD SWINGS		**PLAGIOCEPHALY**	
OBSESSIVE BEHAVIOR		**SEPARATION ANXIETY**	
OPPOSITIONAL DEFIANT		**TEXTURE AVERSIONS**	
SENSORY INTEGRATION PROBLEMS		**BRUSH HAIR INDEPENDENTLY**	
SLEEP DISTURBANCE		**SNAP INDEPENDENTLY**	
BUTTON INDEPENDENTLY		**TIE INDEPENDENTLY**	
ZIP INDEPENDENTLY		**HATES TAGS IN CLOTHING**	
BUCKLE INDEPENDENTLY		**RUN OWN BATH**	
BATHES SELF		**UNDRESS SELF**	
DRIES SELF OFF		**HIGH PAIN THRESHOLD**	
ELOPES		**HURTS ANIMALS**	
SEIZURES			
ADDITIONAL COMMENTS:			

SPEECH AND COMMUNICATION			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
APRAXIA		**NON-VERBAL**	
EXPRESSIVE LANG DELAY		**RECEPTIVE LANG DELAY**	
SPEECH/LANG DELAY		**# OF CLEAR WORDS**	
SPEAKS COMPLETE SENTENCES		**USES SCRIPTED SPEECH**	
ECHOLALIA		**VERBALIZES WANTS/NEEDS**	
USES SIGN LANGUAGE		**FOLLOWS INSTRUCTIONS**	
FOLLOWS PROMPTS		**POINTS TO DESIRED OBJECTS**	
ADDITIONAL COMMENTS:			

INTAKE

SOCIAL/EMOTIONAL/BEHAVIORAL PROBLEMS			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
SOCIAL MALADJUSTMENT		**WANDER IF DISTRACTED**	
AFRAID OF STRANGERS		**IMPULSIVE**	
MOUTHS OBJECTS		**RUNS INTO TRAFFIC**	
INJURIOUS BEHAVIOR		**SELF-INJURIOUS BEHAV.**	
HITS SELF		**HITS OTHERS**	
BITES SELF		**BITES OTHERS**	
KICKS OTHERS		**SCRATCHES OTHERS**	
FEARS STRANGERS		**LEAVES HOUSE ALONE**	
TRANSITIONS POORLY		**PLAYS ALONE**	
SEPARATION ANXIETY		**PLAYS PARALELL TO OTHERS**	
UNDERSTANDS SOCIAL CUES		**DOES WORK W/O PROMPTS**	
HAS MELTDOWNS (DURATION)		**GAZE AVERSION**	
TIC'S – WHAT KIND?		**MAKES FRIENDS EASILY**	
REPETITIVE BEHAV (KIND?)		**SHARES WITH FRIENDS**	
ADDITIONAL COMMENTS:			

DIET AND FEEDING PROBLEMS			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
DIFFICULTY EATING		**FOOD TEXTURE AVERSIONS**	
ON A SPECIAL DIET (KIND?)		**PERCENTILE FOR WEIGHT**	
# OF CONSISTENT FOODS		**PICKY EATER**	
DRINK FROM A BOTTLE		**HOLDS FORK PROPERLY**	
HAS TO BE FED		**OVERSTUFFS MOUTH W/ FOOD**	
TAKES A BABY BOTTLE		**BREAST FED**	
HAS FEEDING TUBE (KIND?)		**GAGS OR CHOKES OFTEN**	
TUBE FEEDING FREQUENCY		**FOOD ALLERGIES (KIND)**	
TUBE FORMULA (TYPE/AMT)		**REQUIRES FEEDING THERAPY**	
FAILURE TO THRIVE		**GASTROENTERITIS**	
GERD			
ADDITIONAL COMMENTS:			

RESPIRATORY PROBLEMS			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
REACTIVE AIRWAY DISEASE		**ASTHMA**	
BRONCHITIS		**CROUP**	
ADDITIONAL COMMENTS:			

INTEGUMENTARY			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
ECZEMA (WHERE?)		**SORES**	
SKIN PICKING		**RASHES**	
ADDITIONAL COMMENTS:			

UROGENITAL AND BOWEL			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
POTTY TRAINED (URINE)		**POTTY TRAINED (BOWEL)**	
NEEDS HELP WITH HYGEINE		**CAN TAKE PANTS UP/DOWN**	
WEARS DIAPERS		**STILL HAS ACCIDENTS**	

INTAKE

CONSTIPATION (TREAT.?)		**WEARS PULL-UP'S**	
ADDITIONAL COMMENTS:			

PLEASE LIST ANY ENDOCRINE PROBLEMS THAT APPLICANT HAS			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
DIABETES		**GROWTH PROBLEMS**	
OTHER			
ADDITIONAL COMMENTS:			

PLEASE LIST ANY ALLERGIES OR IMMUNE PROBLEMS THAT APPLICANT HAS			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
ALLERGIES, ENVIRONMENTAL		**ALLERGIES, FOOD**	
ALLERGIES, MEDICATION		**PEANUT ALLERGY**	
RHINITIS		**OTITIS MEDIA**	
ADDITIONAL COMMENTS:			

PLEASE LIST ANY MUSCLOSKELETAL PROBLEMS THAT APPLICANT HAS			
PROBLEM	**YES – NO – N/A**	**PROBLEM**	**YES – NO – N/A**
FINE MOTOR DELAY		**GROSS MOTOR DELAY**	
HYPOTONIA		**MOTOR COORDINATION PROB**	
CLUMSY OR FREQ FALLS		**GAIT ABNORMALITY**	
HYPERTONIA		**CLUB FOOT (L? OR R?)**	
MUSCLE WEAKNESS		**SCOLIOSIS (DEGREE?)**	
TORTIOCOLLIS		**FREQUENT FALLS**	
AFOs/SMOs (R/L, BOTH?)		**CONTRACTURES**	
HAND/WRIST BRACES		**POOR COORDINATION**	
UNSTEADY GAIT		**TIRES EASILY**	
WALK INDEPENDENTLY		**WHEELCHAIR**	
WALKER		**STANDER**	
DYSMORPHIC FEATURES		**ABNORMAL HEAD SIZE**	
ADDITIONAL COMMENTS:			

INTAKE

PAPERWORK NEEDED FOR THE KATIE BECKETT DEEMING WAIVER

BELOW IS A COMPREHENSIVE LIST OF ITEMS WE NEED.
YOU WILL NOT HAVE ALL OF THESE. PLEASE, SEND WHAT YOU HAVE AS YOU GET IT SO WE CAN WORK ON YOUR PACKET WHILE YOU ARE LOCATING OTHER DOCUMENTS.

- ❒ **PSYCHOLOGICAL (2yrs – 18yrs) OR DEVELOPMENTAL EVALUATION (<5yrs)**
- ❒ **IFSP FROM BABIES CAN'T WAIT (BCW) – IF YOUR CHILD IS < 3 YEARS OLD**
- ❒ **INDIVIDUALIZED EDUCATION PLAN (IEP) – If child is CURRENTLY in School.**
- ❒ **SCHOOL THERAPY EVALUATION AND NOTES**
- ❒ **DISCHARGE SUMMARY FROM BIRTH – IF CHILD WAS HOSPITALIZED > 2 DAYS**
- ❒ **DISCHARGE SUMMARY FROM ANY PREVIOUS HOSPITALIZATION**
- ❒ **THE LAST VISIT NOTE FROM ANY SPECIALISTS YOU HAVE SEEN (ENT, CARDIO, NEURO, GENETICS, PULMONARY, ETC**
- ❒ **ANY OTHER PERTINENT MEDICAL RECORDS**
- ❒ **THERAPY EVALUATION OR PLAN OF CARE FROM *EVERY* CURRENT PRIVATE THERAPY THAT APPLICANT HAS**
- ❒ **PROOF OF INCOME**
- ❒ **COPY OF CHILD'S BIRTH CERTIFICATE**
- ❒ **COPY OF INSURANCE CARD, BOTH SIDES**
- ❒ **COPY OF CHILD'S SS CARD**
- ❒ **CHILD ACCOUNTS – LAST STATEMENT OF ANY ACCOUNT**

NOTE: ONLY SEND US THERAPY EVALUATIONS OR PLANS OF CARE. WE DON'T NEED BOTH.
DO NOT SEND THERAPY NOTES TO US. KATIE BECKETT REQUIRES 90 DAYS OF THERPAY NOTES OR AS MANY AS YOUR CHILD HAS HAD AND THEY WANT THEM TO BE CURRENT TO WHEN YOU SEND THE PACKET IN. WE WILL LET YOU KNOW WHEN WE ARE FINISHED AND THEN, YOU SHOULD COLLECT NOTES WHILE YOU ARE WAITING FOR YOUR PACKET TO ARRIVE.

THANKS SO MUCH!