Developmental Behavioural Services/Aide Program

Office Use Only
Start Date: _____
Team: _____
Initials: _____

Date of Application (mm/dd/yyyy) _____

Exceptional Abilities
Educational Consultation & Tutoring

A Behaviour / Developmental Support Agreement is typically a 6 month contract with one discipline (OT, SLP, Psychology, Behaviour) that is focused on 2-3 achievable objectives within one behavioural / developmental area.

It is a consultation model that includes assessment, priority setting, parent/family coaching, a written plan, a data collection system, coordination with other supports, and (if appropriate) direct intervention.

CHILD'S INFORMATION			
CHILD'S LAST NAME	CHILD'S MIDDLE NAME	CHILD'S FIRST NAME	
GENDER (please circle one) Male Female Non-binary	BIRTH CERTIFICATE #	DATE OF BIRTH (mm/dd/yyyy)	
ADDRESS	CITY	PROVINCE	POSTAL CODE
Was your child assessed?(√) Yes_____No_____ ☐ ☐	IF YES, DATE OF ASSESSMENT (mm/dd/yyyy)		
IF YES, PLACE YOUR CHILD WAS ASSESSED	**PLEASE SUBMIT A COPY OF ASSESSMENT WITH THIS FORM**		

PARENT(S) / GUARDIAN(S) INFORMATION					
1) PARENT/GUARDIAN NAME (First name, Last name)			2) PARENT/GUARDIAN NAME (First name, Last name)		
HOME PHONE #	CELL PHONE #	WORK PHONE #	HOME PHONE #	CELL PHONE #	WORK PHONE #
EMAIL ADDRESS			EMAIL ADDRESS		
OCCUPATION	PLACE OF EMPLOYMENT		OCCUPATION	PLACE OF EMPLOYMENT	
CURRENTLY WORKING? (✓) YES☐ NO☐ If Yes: Full Time☐ Part Time☐ Shift work☐			CURRENTLY WORKING? (✓) YES☐ NO☐ If Yes: Full Time☐ Part Time☐ Shift work☐		

AVAILABILITY FOR CONSULTANT VISITS:
check all that apply - (✓)

	MORNING	AFTERNOON	EVENING
MONDAY	☐	☐	☐
TUESDAY	☐	☐	☐
WEDNESDAY	☐	☐	☐
THURSDAY	☐	☐	☐
FRIDAY	☐	☐	☐

PLEASE NOTE: Evening availability is limited and you may be placed on a waitlist. The last available daytime appointment is 3pm and evening visits end at 6:30pm.

PRIMARY LANGUAGE SPOKEN

OTHER LANGUAGES SPOKEN

IF ENGLISH AS SECOND LANGUAGE: (select one)
1 – Little to none ○ 2 – Basic skills ○ 3 – Speak fluently ○
Read English? (✓) Y_____ N_____ Write in English? Y_____ N_____

IDENTIFIED CULTURE

LENGTH OF TIME IN CANADA

AVAILABILITY FOR CONSULTANT VISITS:
check all that apply - (✓)

	MORNING	AFTERNOON	EVENING
MONDAY	☐	☐	☐
TUESDAY	☐	☐	☐
WEDNESDAY	☐	☐	☐
THURSDAY	☐	☐	☐
FRIDAY	☐	☐	☐

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IDENTIFIED CULTURE

LENGTH OF TIME IN CANADA

FAMILY INFORMATION

Who has legal decision making authority for the child?

Who has legal custody of the child?

Custody arrangements, if applicable. *Please explain and attach documents*

Name of person(s) the child may **NOT** be released to:

PEOPLE WHO RESIDE IN CHILD'S HOME (check all that apply) :

CHECK ALL THAT APPLY	✓	*LIST NAMES AND AGES AS APPROPRIATE*
Parent 1	☐	
Parent 2	☐	
Siblings	☐	
Grandparents	☐	
Aunt/Uncle	☐	
Others	☐	

BARRIERS TO SERVICE

Do you perceive any barriers/challenges to accessing services?

CHECK ALL THAT APPLY	✓	*DESCRIBE FURTHER AS APPROPRIATE*		✓	
Language/communication	☐		Understanding the system	☐	
Limited time	☐		Driving/Transportation	☐	
Identify as low income	☐		Competing demands (work, family, other)	☐	
Other	☐				

How long did you wait to receive a diagnosis of ASD? (if applicable)_____

FAMILY SUPPORT FOR CHILDREN WITH DISABILITIES (FSCD) INFORMATION

Have you been approved for Behavioral or Developmental Supports (BDS)? Yes ☐ No ☐ Have you been approved for Specialized Services (SS)? Yes ☐ No ☐	IF YES, WHEN (mm/dd/yyyy)

If No, where in the process are you?

☐ Information sent to FSCD, waiting for response ☐ Information not sent to FSCD ☐ Other_____

Have you ever received FSCD funded Behavioral, Developmental or Specialized Services in the past?

YES☐ NO☐ If YES: Start Date_____ End date:_____

If YES: Start Date_____ End date:_____

If approved for BDS, what significant support needs were identified by FSCD as requiring support? ☐ Check if Don't Know / Unsure

If known, check all that apply:

☐ Communication / Socialization ☐ Behaviour ☐ Self-Help and Adaptive ☐ Fine and Gross Motor Skills ☐ Cognitive

If approved for BDS, what discipline(s) was/were identified as needed? ☐ Check if Don't Know / Unsure

If known, check all that apply:

☐ Behavioural Consultant ☐ Speech Language Pathologist ☐ Occupational Therapist ☐ Psychologist ☐ Other: _____

What is your **main goal** for accessing these supports?

FSCD NUMBER	CASE WORKER'S NAME

Please initial here to provide consent to contact FSCD and discuss the status of your agreement (required): _____

Though gathered for information, we will NOT contact ECS, schools or other agencies without additional consents from you (below).

EARLY CHILDHOOD SERVICES (ECS) INFORMATION (if applicable)

Has your child ever received Early Childhood Supports - Program Unit Funding (PUF)? ☐ Yes ☐	FOR HOW MANY YEARS?	YEAR OF CURRENT OR PREVIOUS PUF:

NAME OF PRESCHOOL(S) OR KINDERGARTEN(S)

Is your child <u>currently</u> in PUF? ☐ Yes ☐ No	NAME OF PRESCHOOL/KINDERGARTEN
Will your child be PUF eligible this coming Sept? ☐ Yes ☐ No	NAME OF PRESCHOOL/KINDERGARTEN (if known)

SCHOOL INFORMATION (if applicable)

NAME OF SCHOOL	PHONE NUMBER
GRADE	TEACHER NAME

PROGRAM (Regular class, Interactions, Other, etc)

BEHAVIOURAL THERAPIST	BEHAVIOURAL AID
NAME	NAME
EMAIL AND PHONE NUMBER	EMAIL AND PHONE NUMBER

OTHER AGENCIES

AGENCIES OR PROGRAMS YOUR CHILD IS **CURRENTLY** INVOLVED IN	DAYCARE or OUT OF SCHOOL CARE		
	Name:	Start Date:	End Date:
	Other agency/program names:		
	Name:	Start date:	End date:
	Name:	Start date:	End date:
AGENCIES OR PROGRAMS YOUR CHILD HAS **PREVIOUSLY BEEN** INVOLVED IN	Agency/Program		
	Name:	Start date:	End date:
	Name:	Start date:	End date:
	Name:	Start date:	End date:

HOME VISITS

CONSULTANT VISITS	• Visits by the clinician providing your service (e.g., Behavioural Consultant, Occupational Therapist, or Speech-Language Pathologist). • Occurs on weekdays, starting no earlier than **8:00am** and concluding no later than **7:30pm.** Schedule, frequency and length determined prior to service start. • Exceptions will be made if necessary (for example - when doing bed time or wake-up routines). Visits are for home and community participation activities (not school).

EMERGENCY CONTACT INFORMATION (other than parent/guardian)

LAST NAME, FIRST NAME	HOME PHONE #	CELL PHONE #	RELATIONSHIP TO CHILD

CHILD'S HEALTH INFORMATION

ALBERTA HEALTH CARE NUMBER	PHYSICIAN'S NAME	PHONE #

ALLERGIES (any known allergies including food)

RELEVANT HEALTH INFORMATION	Provide any information that is useful to medical professional in case of emergency:
OTHER MEDICAL/EMERGENCY REQUESTS	Please list any additional diagnoses, hospitalizations or referrals and include DATES:

IN CASE OF EMERGENCY

In case of emergency and in my absence, I authorize, by my signature below, that the staff of Exceptional Abilities may give my child emergency care on site or transport them to an outside location. All medical aid, above and beyond first aid, will be administered by public emergency response teams and by qualified medical personnel only.

I give consent for Exceptional Abilities staff to arrange for any medical treatment and/or ambulance service should it be required in the event of an illness or injury. I understand that payment for this service is my responsibility.

SIGNATURE _____ DATE (mm/dd/yy) _____