

Developmental Behavioural Services/Aide Program

Office Use Only

Start Date: _____

Team: _____

Initials: _____

Date of Application (mm/dd/yyyy) _____



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?(v) 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 - (✓) <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <th></th><th>MORNING</th><th>AFTERNOON</th><th>EVENING</th></tr> <tr><td>MONDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>TUESDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>WEDNESDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>THURSDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>FRIDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> </table> 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 _____		MORNING	AFTERNOON	EVENING	MONDAY	☐	☐	☐	TUESDAY	☐	☐	☐	WEDNESDAY	☐	☐	☐	THURSDAY	☐	☐	☐	FRIDAY	☐	☐	☐	AVAILABILITY FOR CONSULTANT VISITS: check all that apply - (✓) <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <th></th><th>MORNING</th><th>AFTERNOON</th><th>EVENING</th></tr> <tr><td>MONDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>TUESDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>WEDNESDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>THURSDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> <tr><td>FRIDAY</td><td>☐</td><td>☐</td><td>☐</td></tr> </table> 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 _____		MORNING	AFTERNOON	EVENING	MONDAY	☐	☐	☐	TUESDAY	☐	☐	☐	WEDNESDAY	☐	☐	☐	THURSDAY	☐	☐	☐	FRIDAY	☐	☐	☐
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FAMILY INFORMATION																																																	
Who has legal decision making authority for the child?																																																	
Who has legal custody of the child?																																																	
Custody arrangements, if applicable. <i>Please explain and attach documents</i>																																																	
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	
1. What is Family Support for Children with Disabilities (FSCD)? FSCD is a program that provides support and resources to families of children with disabilities. It is designed to help families understand their child's needs, access services, and advocate for their child's rights. FSCD is a free, confidential, and confidential service provided by the Department of Social Services (DSS).	2. How can I get FSCD services? You can get FSCD services by contacting your local DSS office or the FSCD helpline at 1-800-368-7263. You will need to provide some information about your child and your family to qualify for the program.
3. What services does FSCD provide? FSCD provides a variety of services, including: • Information and referrals to community resources • Advocacy and support groups • Training and technical assistance • Crisis intervention and support	4. How can I get more information about FSCD? You can get more information about FSCD by visiting the FSCD website at www.fscd.org or by calling the FSCD helpline at 1-800-368-7263.

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 _____

☒ 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 ☐

☒ Yes ☐

FOR HOW MANY YEARS?

YEAR OF CURRENT OR PREVIOUS PUF:

NAME OF PRESCHOOL(S) OR KINDERGARTEN(S)

Is your child currently in PUF? ☐ Yes ☐ No

Is your child currently 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	
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TEACHER NAME	
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PROGRAM (Regular class, Interactions, Other, etc)

BEHAVIOURAL THERAPIST

BEHAVIOURAL AID

NAME

[illegible]

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 the Centre for Autism Services Alberta, and its subsidiary programs, 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 to Centre for Autism Services Alberta staff to arrange for any medical treatment and/or ambulance 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) _____	