Integrated
Development
**SERVICES**

**IDS – MADISON**
559 Zor Shrine Place
Madison, WI 53719
608-833-0123
800-218-3781

**IDS – MILWAUKEE**
4125 N 124th Street
Ste. A & B
Brookfield, WI 53005
414-763-2341
800-218-3781

# INITIAL WELCOME PACKET

*The completion of this form is not an intake for services with IDS.

## Hello and thank you for seeking out more information about services at IDS.

Please fill out our Initial Welcome Packet in order to help us to get to know what type of services you are seeking. Upon completing the Initial Welcome Packet, you can email it to intake@ids-wi.com, mail it to our Madison, WI regional office, or fax it to 608-833-0126. Once we receive your completed packet, we will start the pre-authorization process and give you a call to set up your initial appointment. We look forward to working with you and your family. If you have any questions, please call our Intake Specialist at 608-410-0501 or email intake@ids-wi.com. Thank you again, and Welcome!

### CLIENT INFORMATION

CLIENT NAME (FIRST, MI, LAST)

ADDRESS (STREET, CITY, STATE, ZIP)

DATE OF BIRTH

HOME PHONE

COUNTY OF RESIDENCE

GENDER

DIAGNOSING CLINICIAN/ CLINIC

DIAGNOSES

REFERRED BY/ HOW DID YOU HEAR ABOUT IDS?

### PARENT OR GUARDIAN

If Client is a minor or is an adult who has a guardian, please complete parent/guardian information.

| PARENT/GUARDIAN NAME | | PARENT/GUARDIAN NAME | |
|---|---|---|---|
| DATE OF BIRTH | RELATIONSHIP TO CLIENT | DATE OF BIRTH | RELATIONSHIP TO CLIENT |
| ADDRESS (IF DIFFERENT THAN CLIENT) | | ADDRESS (IF DIFFERENT THAN CLIENT) | |
| CELL PHONE | EMAIL ADDRESS | CELL PHONE | EMAIL ADDRESS |

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# INITIAL WELCOME PACKET

## CLIENT PROFILE

PLEASE TELL US ABOUT YOURSELF – YOUR STRENGTHS, SPECIAL ABILITIES, PERSONALITY TRAITS, CHARACTERISTICS, ETC.

PLEASE COMPLETE THE FOLLOWING INFORMATION IN ORDER TO HELP US LEARN MORE ABOUT YOU:

## CURRENT THERAPIES/INTERVENTION (OT, Speech, PT, ABA, MH, GF/CF diet, hyperbaric, dvr, wrap around services)

| TYPE | PROVIDER OR CASE MANAGER/HOSPITAL | START DATE | END DATE | EFFECTIVENESS |
|---|---|---|---|---|

## SUPPORTIVE RELATIONSHIPS (Spouse, close relative, person whom you live with, case manager)

| TYPE OF RELATIONSHIP | NAME OF PERSON |
|---|---|

## PAST THERAPIES/INTERVENTION (OT, Speech, PT, ABA, MH, GF/CF diet, hyperbaric, dvr, wrap around services)

| TYPE | PROVIDER OR CASE MANAGER/HOSPITAL | START DATE | END DATE | EFFECTIVENESS |
|---|---|---|---|---|

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# INITIAL WELCOME PACKET

## SOCIAL SKILLS

HELP US UNDERSTAND HOW YOU INTERACT WITH YOUR FAMILY AND PEERS (CHECK ALL THAT APPLY)

| **DO YOU:** | | PLEASE DESCRIBE: |
| --- | --- | --- |
| ENJOY ENGAGING WITH PEERS OR OTHER ADULTS | | |
| PREFER TO DO ACTIVITIES ALONE OR BE BY YOURSELF | | |
| INITIATE INTERACTIONS WITH PEERS OR OTHER ADULTS | | |
| ENGAGE IN RECIPROCAL ACTIVITIES OR CONVERSATION WITH PEERS OR ADULTS | | |
| ENGAGE IN LEISURE ACTIVITIES OUTSIDE YOUR HOME WITH PEERS OR OTHER ADULTS | | |

## BEHAVIOR

HELP US UNDERSTAND ANY BEHAVIORS THAT HAVE AN IMPACT ON YOUR LIFE OR THOSE AROUND YOU (CHECK ALL THAT APPLY)

| **DO YOU:** | | PLEASE DESCRIBE THE BEHAVIORS. WHAT CIRCUMSTANCES LEAD TO THIS BEHAVIOR? WHAT ENVIRONMENTS DO THESE BEHAVIORS HAPPEN IN? |
| --- | --- | --- |
| ENGAGE IN VERBAL/PHYSICAL AGGRESSION TOWARDS SELF | | |
| ENGAGE IN VERBAL/PHYSICAL AGGRESSION TOWARDS OTHERS AND/OR YOUR HOME ENVIRONMENT | | |
| DAMAGE PROPERTY | | |
| NOT DEMONSTRATE ANY BEHAVIORAL CONCERNS | | |

OTHER COMMENTS IN REGARDS TO YOUR SOCIAL SKILLS:

OTHER COMMENTS IN REGARDS TO YOUR BEHAVIOR:

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# INITIAL WELCOME PACKET

## COMMUNICATION SKILLS

HELP US UNDERSTAND HOW YOU GET YOUR NEEDS MET (CHECK ALL THAT APPLY)

| **DO YOU:** | | PLEASE DESCRIBE: |
|---|---|---|
| USE GESTURES | | |
| USE SOME SIGN LANGUAGE | | |
| USE SOME PICTURES/VISUALS | | |
| MAKE SOME SOUNDS | | |
| USE WORD APPROXIMATIONS | | |
| USE A FEW WORDS | | |
| USE FULL SENTENCES | | |
| ASK QUESTIONS | | |
| ANSWER QUESTIONS | | |
| INITIATE CONVERSATIONS | | |
| ASK OR ADVOCATE FOR YOUR NEEDS TO BE MET | | |

OTHER COMMENTS IN REGARDS TO YOUR COMMUNICATION SKILLS:

I UNDERSTAND THAT THE INFORMATION REPORTED ON THIS FORM WILL REMAIN STRICTLY CONFIDENTIAL AND WILL BE USED FOR THE PURPOSE OF IDENTIFYING APPROPRIATE TREATMENT SERVICES FOR THE CLIENT.

SIGNATURE OF CLIENT OR PARENT/GUARDIAN

DATE

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# INITIAL WELCOME PACKET

## INSURANCE INFORMATION

* We require a complete copy of your insurance card/s (front and back) along with this completed form.

✔ I DO NOT HAVE INSURANCE BENEFITS TO COVER THE SERVICES I WILL BE RECEIVING AND AGREE TO PAY MY BILL PERSONALLY AT THE TIME OF SERVICES. IF I AM UNABLE TO PAY IN FULL, I WILL MAKE PAYMENT ARRANGEMENTS WITH THE ACCOUNTING OFFICE. (PLEASE CHECK IF THIS APPLIES.)

PRIMARY CARRIER* | PHONE NUMBER

ADDRESS

POLICY HOLDER | POLICY/MEMBER # | PERSON CODE | GROUP #

*PLEASE PROVIDE COPY OF THE FRONT AND BACK OF INSURANCE CARD

SECONDARY CARRIER* | PHONE NUMBER

ADDRESS

POLICY HOLDER | POLICY/MEMBER # | PERSON CODE | GROUP #

*THIS INCLUDES MEDICAID, TITLE 19, AND KATIE BECKETT

## SIGNATURE ON FILE

- I AUTHORIZE USE OF THIS SIGNATURE FORM ON ALL MY INSURANCE SUBMISSIONS.
- I AUTHORIZE IDS TO RELEASE TO MY INSURANCE COMPANY ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
- I AUTHORIZE PAYMENT DIRECTLY TO INTEGRATED DEVELOPMENT SERVICES, LLC.
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- I UNDERSTAND THAT THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT REMAINS VALID UNLESS EXPRESSLY REVOKED.
- I HEREBY RELEASE IDS FROM ANY LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT OF FILING MY INSURANCE CLAIM.
- I HAVE BEEN ADVISED OF THE COST OF TREATMENT.

NAME OF CLIENT

DATE OF BIRTH

NAME OF PARENT/GUARDIAN

SIGNATURE OF CLIENT OR PARENT/GUARDIAN

TODAY'S DATE