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 your family's needs. 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, please complete parent/guardian information. *Address need only be completed if different than Client.

PARENT/GUARDIAN NAME

DATE OF BIRTH

RELATIONSHIP TO CLIENT

ADDRESS (IF DIFFERENT THAN CLIENT)

CELL PHONE

EMAIL ADDRESS

PARENT/GUARDIAN NAME

DATE OF BIRTH

RELATIONSHIP TO CLIENT

ADDRESS (IF DIFFERENT THAN CLIENT)

CELL PHONE

EMAIL ADDRESS

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CHILD PROFILE

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

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

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

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

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

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

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SOCIAL SKILLS

HELP US UNDERSTAND HOW YOUR CHILD INTERACTS WITH YOUR FAMILY AND HIS/HER PEERS (CHECK ALL THAT APPLY)

DOES YOUR CHILD:		PLEASE DESCRIBE:
SHOW INTEREST IN SIBLING OR PEERS		
PREFER TO PLAY BY HIM/HER SELF		
INITIATE PLAY WITH SIBLING OR PEERS		
ENGAGE IN BACK AND FORTH PLAY WITH A SIBLING OR PEER		
ENGAGE IN GAMES WITH RULES WITH A SIBLING OR PEER		

BEHAVIOR

HELP US UNDERSTAND ANY BEHAVIORS THAT ARE ABOVE AND BEYOND WHAT IS AGE APPROPRIATE FOR YOUR CHILD (CHECK ALL THAT APPLY)

DOES YOUR CHILD:		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		
DAMAGE PROPERTY		
NOT DEMONSTRATE ANY BEHAVIORAL CONCERNS		

OTHER COMMENTS IN REGARDS TO YOUR CHILD'S SOCIAL SKILLS:

OTHER COMMENTS IN REGARDS TO YOUR CHILD'S BEHAVIOR:

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INITIAL WELCOME PACKET

COMMUNICATION SKILLS

HELP US UNDERSTAND HOW YOUR CHILD GETS HIS/HER NEEDS MET (CHECK ALL THAT APPLY)

DOES YOUR CHILD:		PLEASE DESCRIBE:
USE GESTURES (POINTING, LEADS YOU BY HAND)		
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		

OTHER COMMENTS IN REGARDS TO YOUR CHILD'S 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