



# Integrated Development SERVICES

**IDS – WESTERN WISCONSIN**  
1477 South Knowles Avenue  
Suite 103  
New Richmond, WI 54017  
715-246-9762

## 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](mailto:intake@ids-wi.com), mail it to our New Richmond, WI regional office, or fax it to 715-246-3596. 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 715-246-9762 or email [intake@ids-wi.com](mailto: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

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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### 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
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#### 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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### 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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**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

NAME OF CLIENT

- 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.

DATE OF BIRTH

NAME OF PARENT/GUARDIAN

SIGNATURE OF CLIENT OR PARENT/GUARDIAN

TODAY'S DATE