Elevated Kids

Thank you for your inquiry regarding an Autism Evaluation through Elevated Kids, Autism Evaluation Service.

The Elevated Kids Autism Evaluation Service provides a comprehensive Autism Evaluation using the evidence-based, gold standard Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) to assess for Autism Spectrum Disorders (ASD). All Autism Evaluations are provided by a Board Certified Behavior Analyst (BCBA) with post-graduate clinical training and advanced certification in the ADOS-2 assesment tool, used to help diagnose Austism Spectrum Disorders (ASD).

The Autism Evaluation takes approximately 4-6 hours and consists of:

- Comprehensive parent/caregiver diagnostic interview/review of child development and medical records
- Unstructured play observation
- Structured play-based assessment (ADOS-2)
- A feedback session outlining the assessment outcomes
- Recommendations for intervention/treatment and follow-up
- Comprehensive written report within one month of the assessment date, summarizing the assessment process, as well as any outcomes and recommendations.

Please complete and return the enclosed consent and intake forms as soon as possible to begin the Autism Evaluation process. Please include copies of any reports that have been previously completed (e.g. pediatrician's report, psychometric assessment, speech and language assessment, evaluation report, IFSP, IEP). Once we have received the completed forms, all information will be reviewed in its entirety for completeness. An intake officer from the Autism Evaluation team will be in contact with you to discuss the evaluation and schedule a visit.

Please E-Mail all information to: *info@elevatedkids.com*

We thank you for allowing us the privilege of entrusting your child's care to us and look forward to partnering with you to develop a plan that is specific to you and your child's needs.

Should you have any further questions, please do not hesitate to contact Elevated Kids at 267-978-4305.

Sincerely,

Amberly Caballero, MSEd, BCBA, LBS, IECMH
Executive Director/Owner
Elevated Kids, LLC

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Evaluation Consent Form

Name of Client: _____ **DOB:** _____

Part A - Permission for Consultancy

I give permission for a professional from Elevated Kids to act as a consultant:

- To seek all relevant information as required from schools, clinics, and other educational and health services;
- To undertake any appropriate and relevant psychological assessments;
- To provide advice and assistance with developmental/behavioral programs that are appropriate and relevant;
- We/I understand that the service will provide us/me with any reports and assessments and that we/I as parent/s or guardian/s will be full participants in any and all decisions which might be made about our child;
- We/I understand that all material will be treated with respect for our rights to privacy and confidentiality;
- We/I will advise Elevated Kids if this evaluation has been requested as a result of any current legal proceedings, e.g. Family Court matter;
- We/I confirm legal guardianship of this child.

We/I understand that fees for consultancy and assessment services will apply, as per attached Fee Schedule. Fees are payable prior to time of scheduled appointment.

Part B – Consent to Maintain Records/Information

I hereby consent to Elevated Kids maintaining records (either paper or electronic/digital format) about the services provided. I understand that:

- These records are owned by Elevated Kids;
- Information within these records will be shared with other staff within Elevated Kids on a 'need to know' basis, if and only when the staff require the information to carry out their duties;
- My consent will be obtained if any records need to be released to another agency or if another agency is contacted to provide information utilizing the BEIS Voluntary Authorization to Release Information form;
- I can ask to see records and receive a copy at any time;
- Records are archived by Elevated Kids for a set period of time according to PA policy and will eventually be destroyed;
- I understand that all sessions are recorded and photos/video footage may be kept in records but will not be used for any other purpose without consent;
- I understand that all information obtained will be kept confidential.

☐ **I acknowledge that I have read, understand and agree to the above information.**

Name of Client/Parent/Guardian: _____

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Evaluation Intake Form

Date: _____
Admission Status: [X] New Referral

Referral Source Information

Agency, School, Etc.: _____ Contact Name: _____
Relationship to Client: _____
Address: _____
City, State: _____ Zip: _____ Phone: _____
Diagnosis: _____ Diagnosing MD: _____
Reason for Referral:

Services Required

[X] Outpatient [X] Autism Evaluation [ ]
Current Therapy (Where/When): _____
Current Placement: _____
Prior Therapy (Where/When): _____

Client Information

Client's Name: _____ DOB: _____
Address: _____
SS#: _____ MA#: _____ School: _____
Parent/Guardian Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail: _____
Non-Custodial Parent Name: _____ Phone: _____
Emergency Contact Name: _____ Relationship: _____ Phone: _____
Family Physician Name: _____ Phone: _____

Public Insurance Information

Magellan: [ ] County:_____ CBH: [ ] CCBH: [ ] County:_____
Perform Care: [ ] State:_____ Other: _____

Private Insurance Information

Insurance Carrier: _____
Address: _____
Subscriber's Name: _____ DOB: _____
Address: _____
ID#: _____ Group #: _____ SS#: _____
Employer's Name: _____ Phone: _____
Address: _____
HR-Benefits Contact Name: _____
Self-Insured Group: [ ]YES [ ]NO 51+Employee Group: [ ] YES [ ] NO
Policy Effective Date: _____ Renewal Date: _____ Act 62 Renewal Date: _____