

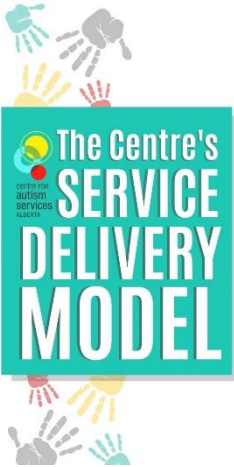
BEHAVIOUR / DEVELOPMENTAL SUPPORTS (BDS) APPLICATION

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 through the Glenrose Hospital?(√) Yes _____ No _____			IF YES, DATE OF ASSESSMENT (mm/dd/yyyy)		
IF NO, PLACE YOUR CHILD WAS ASSESSED			DATE OF ASSESSMENT (mm/dd/yyyy)		
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 the apply- ✓)

	MORNING	AFTERNOON	EVENING
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			

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 630pm.

AVAILABILITY FOR CONSULTANT VISITS:
(check all the apply- ✓)

	MORNING	AFTERNOON	EVENING
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			

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 630pm.

PRIMARY LANGUAGE SPOKEN

PRIMARY LANGUAGE SPOKEN

OTHER LANGUAGES 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 _____

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 _____

IDENTIFIED CULTURE _____ LENGTH OF TIME IN CANADA _____

FAMILY INFORMATION

Who has legal decision making authority for the child?

Who has legal custody of the child?

Custody arrangements, if applicable. *Please explain and attach documents*

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

Have you been approved for Behavioral or Developmental Supports (BDS)? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you been approved for Specialized Services (SS)? Yes <input type="checkbox"/> No <input type="checkbox"/>	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 _____

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)? <input type="checkbox"/> Yes <input type="checkbox"/> No	FOR HOW MANY YEARS?	YEAR OF CURRENT OR PREVIOUS PUF:
---	---------------------	----------------------------------

NAME OF PRESCHOOL(S) OR KINDERGARTEN(S)

Is your child <u>currently</u> in PUF? <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF PRESCHOOL/KINDERGARTEN
---	--------------------------------

Will your child be PUF eligible this coming Sept? <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF PRESCHOOL/KINDERGARTEN (if known)
--	---

SCHOOL INFORMATION (if applicable)

NAME OF SCHOOL	PHONE NUMBER
----------------	--------------

GRADE	TEACHER NAME
-------	--------------

PROGRAM (Regular class, Interactions, Other, etc)

RESPITE INFORMATION (if applicable)

NAME OF RESPITE AGENCY	PHONE NUMBER
------------------------	--------------

RESPITE SCHEDULE

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	<ul style="list-style-type: none"> • Visits by the clinician providing your service (e.g., Behavioural Consultant, Occupational Therapist, or Speech-Language Pathologist). • Occurs on weekdays, starting no earlier than 9:00am and concluding no later than 6:30pm. 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			
<p>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.</p> <p>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.</p>			
SIGNATURE _____		DATE (mm/dd/yy) _____	