centre FOR autism services ALBERTA

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 (or two) discipline(s) (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 check 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 NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER	HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
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.

PARENT(S) / GUARDIAN(S) INFORMATION (continued)

LANGUAGE FLUENCY AND CULTURAL IDENTIFICATION IS USED TO HELP WITH STAFF PLACEMENT & SUPPORT NEEDS

PRIMARY LANGUAGE SPOKEN	PRIMARY LANGUAGE SPOKEN
OTHER LANGUAGES SPOKEN	OTHER LANGUAGES SPOKEN
IF ENGLISH AS SECOND LANGUAGE: (select one) Little to none ○ Basic skills ○ Speak fluently ○ Read English? (√) Y ☐ N ☐ Write in English? Y ☐ N ☐	IF ENGLISH AS SECOND LANGUAGE: (select one) Little to none ○ Basic skills ○ Speak fluently ○ Read English? (√) Y ☐ N Write in English? Y ☐ N ☐
IDENTIFIED CULTURE / RELIGION / ETHNICITY LENGTH OF TIME IN CANADA	IDENTIFIED CULTURE / RELIGION / ETHNICITY 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/CHALLENGES TO SERVICE

PLEASE NOTE: selecting any of the following does **not** impact eligibility for services

Do you perceive any barriers/challenges to accessing services?

CHECK ALL THAT APPLY	√	***DESCRIBE FURTHER AS APPROPRIATE***
Language/Communication	☐	
Limited Time	☐	
Identify as Low Income	☐	
Understanding the System	☐	
Driving/Transportation	☐	Do you drive/have access to transportation? YES ☐ NO ☐
Competing Demands (work, family, other)	☐	
Other	☐	
No barriers identified	☐	Prefer not to answer ☐

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☐ NO☐
Have you been approved for Specialized Services (SS)? YES☐ NO☐

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:_____

FAMILY SUPPORT FOR CHILDREN WITH DISABILITIES (FSCD) INFORMATION (continued)

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? If known, check all that apply: Check if Don't Know / Unsure

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)? YES ☐ NO ☐	FOR HOW MANY YEARS?	YEAR OF CURRENT OR PREVIOUS PUF:

NAME OF PRESCHOOL(S) OR KINDERGARTEN(S) YOUR CHILD HAS ATTENDED (if appliccable)

Is your child currently in PUF? YES ☐ NO ☐	IF YES, NAME OF PRESCHOOL/KINDERGARTEN
Will your child be PUF eligible this coming Sept? YES ☐ NO ☐	IF YES, NAME OF PRESCHOOL/KINDERGARTEN THEY WILL ATTEND (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:

OTHER AGENCIES - continued

	Agency/Program		
AGENCIES OR PROGRAMS YOUR CHILD HAS **PREVIOUSLY BEEN** INVOLVED IN	Name:	Start date:	End date:
	Name:	Start date:	End date:
	Name:	Start date:	End date:

HOME VISITS

CONSULTANT VISITS	• 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). • Occurs in your home or in the community.

EMERGENCY CONTACT INFORMATION (other than parent/guardian)

LAST NAME, FIRST NAME	HOME PHONE NUMBER	CELL PHONE NUMBER	RELATIONSHIP TO CHILD

CHILD' S HEALTH INFORMATION

ALBERTA HEALTH CARE NUMBER	PHYSICIAN'S NAME	PHONE NUMBER

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

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.

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.

SIGNATURE_____ DATE (mm/dd/yyyy)_____