



1260 Iroquois Ave., Suite 306  
Naperville, IL 60563  
P: 630-210-2357  
E: [services@instructional-aba.com](mailto:services@instructional-aba.com)

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Dear Sir or Madam,

Thank you for inquiring about in-home ABA (Applied Behavior Analysis) services with Instructional ABA Consultants. Instructional ABA Consultants mission is to provide quality ABA services to all children and adults with developmental disabilities regardless of their resource availability. Our ABA program includes behavior reduction, discrete trials and precision teaching to obtain individual goals. Parent involvement is required and a parent or a responsible adult must be present in the home while program managers and therapist work with the child.

Please complete the initial Intake Form so that we can begin the intake process as promptly as possible. Additional documentation may be requested at a later time to ensure that we have all the necessary information to provide you with quality service.

The Intake Form can be emailed, faxed or mailed to our Naperville office.

Email: [services@instructional-aba.com](mailto:services@instructional-aba.com)

Fax: 331-229-8843

Mailed to:  
Instructional ABA Consultants  
1260 Iroquois Ave., Suite 306  
Naperville, IL 60563  
Attn: Intake

We will review the information once it is received, and contact you with any further questions. Once the individual is determined eligible and appropriate for ABA services, they will be placed on a waitlist and services will be provided as staffing is available in your location. It is difficult to predict when there will be openings in a specific area so we encourage you to explore other programs to determine what is best for your child.

If you have any additional questions, please feel free to call 630-210-2357.

Best Regards,

*Instructional ABA Consultants*

Client Name: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Instructional ABA Consultants Intake Form**

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Client Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Method of Communication:  Verbal  Non-Verbal  SignRace (Optional):  Caucasian  African American  Latino  Asian American Indian/Alaskan Native  Hawaiian/Pacific Islander

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Interpreter Needed:  Yes  No**Parent 1 or Guardianship Status Family:** Office of State Guardianship / Self / Other  
(circle one)

Parent 1 or Guardian Name:

\_\_\_\_\_  
(Last) (First) (Middle)Guardian Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Guardian Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Guardian Email: \_\_\_\_\_

**Parent 2 or Guardianship Status Family:**

Parent 2 or Guardian Name:

\_\_\_\_\_  
(Last) (First) (Middle)Guardian Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Guardian Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Guardian Email: \_\_\_\_\_

**Primary Contact and Preferred Method of Communication**Name: \_\_\_\_\_  Home Phone number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  Email: \_\_\_\_\_



### Payment Information

Insurance: Please complete the following forms and submit with the intake packet

Please circle the type of insurance you carry:

Blue Cross Blue Shield    Aetna    Cigna    United Healthcare    Magellan    Humana    LifeSynch

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Co \_\_\_\_\_ Insurance phone # \_\_\_\_\_

Member ID: \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Insurance Self-Funded (circle): YES NO

Copy of Insurance card – front and back

**\*\*If your insurance is not listed above, please contact us for additional information**

Medicaid: Please complete the following forms and submit with the intake packet

*A home-based waiver is required for the individual requesting services*

DHS Service Award Letter (copy)

Service Coordinator Name: \_\_\_\_\_

Agency \_\_\_\_\_ Phone Number \_\_\_\_\_

Email Address: \_\_\_\_\_

Private Pay:

For private pay service rates and payment plans, please contact our Billing Specialist at 331-229-8839.



### Parent / Guardian Questionnaire

Has the client received behavior therapy before:  Yes  No

If so, what services and when? \_\_\_\_\_

What kind of services are you looking for?

Please check all that apply:

- Line Therapy
- Parent Training

Location

- In-home
- Clinic (Naperville Location)

Parent Goals/Need for ABA Services:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_