Brenner Children's

Amos Cottage
Therapeutic Day Program &
Outpatient Therapy

3325 Silas Creek Parkway
Winston-Salem, NC 27103
p 336.713.7497
f 336.702.9199
www.wakehealth.edu/locations/clinics/t/therapeutic-day-program

Dear Parent(s)/Guardian(s):

Thank you for your interest in the Amos Cottage Therapeutic Day Program Outpatient Therapy. Enclosed you will find the admission application which includes:

- Program Fact Sheet
- Parent Program Information Sheet
- Admission Assessment *(to be completed by parent/guardian)*
- Financial Coverage & Assistance Request *(to be completed by parent/guardian)*
- School Info Request *(to be completed by daycare or school staff)*
- School Behavior Intervention Plan *(to be completed by daycare or school staff)*

You will also find the following Authorization for Use of Disclosure of Protected Health Information Forms; one for your child's primary care provider and one for your child's school/daycare. These forms allow us to speak to your child's primary care provider and also your child's school/daycare, and also receive and release records as needed to support your child's treatment. Make sure to fill out each section.

- Child's name and date of birth.
- Primary care provider and/or school/daycare name and complete address.
- Your signature and date/time of signature, along with your relationship to the child

If applicable, please include other supporting documentation that may be helpful during this screening process, such as an IEP, psychological evaluation, speech/language evaluation, etc.

In addition, you will be receiving an email with a link to an online assessment from Q-global. Please click on the link and complete the form.

If you have any questions about the application process, please contact me at (336) 713-7497.

We look forward to working with you and your child.

Sincerely,

Cindy DiNicolas
Administrative Assistant
Amos Cottage Therapeutic Day Program
Wake Forest Baptist Health
Ph: (336) 713-7497
Fax: (336) 702-9199

Atrium Health Wake Forest Baptist

Brenner Children's
WAKE FOREST BAPTIST HEALTH

INTRODUCTION TO AMOS COTTAGE THERAPEUTIC DAY PROGRAM AND OUTPATIENT COUNSELING SERVICES

- **Accredited and Licensed by State of NC Department of Health and Human Services, Division of Mental Health to provide day treatment services for children ages 3-7 with behavioral/emotional disorders. Outpatient counseling services supporting children ages 3-12. The program is part of the Department of Behavioral and Developmental Pediatrics with Atrium Health Wake Forest Baptist**

- **Program operates 5 hours daily Monday through Friday year- round 9:00AM-2:00PM.**

- **Credentialed by Local Management Entities within the region which include Partners, VAYA, and Sandhills**

- **The multi-disciplinary treatment team includes the following professionals:**

  - ***Clinical Social Worker trained in Trauma Informed practices also possessing extensive experience counseling young children and their families.***
  - ***Licensed Psychological Associate with extensive experience supporting children with severe behavioral challenges coupled with specialized training in Cognitive Behavior Therapy and current parenting practices which include SPACE/Supportive Parenting for Anxious Childhood Emotions.***
  - ***Board Certified Music Therapist trained in music and neurologic-based music therapy methods.***
  - ***Licensed Recreational Therapists utilizing activity-based interventions to address the assessed mental health needs of the clients as a means to stabilize behavior and develop core social and emotional competency skills.***
  - ***Behavioral Specialists teaching from a therapy based curriculum targeting the development of pro-social behavior supporting eventual school transition.***
  - ***Licensed teacher is also on site providing academic instruction following the NC Standard Course of Study.***

- **Developmental and Behavioral Pediatricians from Wake Forest University School of Medicine are on site for consultation and medication management if deemed advisable.**

- **Professional therapy staff will provide training for classroom personnel when child is ready to transition back into his/her school setting.**

- **Transportation Services are available for eligible clients.**

- **Outpatient Counseling Services are provided on site by licensed clinicians who utilize creative, yet highly effective counseling techniques specifically designed to support the 'younger' child and family.**

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage TDP Outpatient Therapy Clinic
Admission Assessment

Childs Full Name: _____

Date of Birth: _____ Race: _____ Gender: _____

Social Security Number: _____

Mothers' Name: _____ Date of Birth: _____

Fathers' Name: _____ Date of Birth: _____

Name and address of person with whom the child resides (include street, city, and zip code):

_____

_____

_____

County of Residence: _____ Home Phone: _____

Email Address: _____

Parents (check one): ☐ Married ☐ Unmarried ☐Separated ☐ Divorced ☐ Widowed

Who has legal custody of the child? _____

Please list all persons living in child's home and their date of birth:

_____

_____

_____

Mothers' occupation: _____ Mothers' work phone: _____

Mothers' employer: _____ Highest school grade completed: _____

Fathers' occupation: _____ Fathers' work phone: _____

Fathers' Employer: _____ Highest school grade completed: _____

INSURANCE INFORMATION:

Child's Insurance Provider: _____

If Medicaid, list what type of Medicaid and Medicaid number: _____

_____

Amos Cottage TDP Outpatient Therapy Clinic
Admission Assessment

PRE-SCHOOL/SCHOOL HISTORY

Does your child attend daycare, preschool, or school? _____ If yes, list name and address of program and how long child has been enrolled: _____
_____

Does child receive any special therapies or services (i.e., speech therapy, early intervention, other?) _____
If so, explain: _____
_____

Does your child have an IEP? _____ Has the IST process started? _____ **(If your child has an IEP, kindly provide the program with a copy)**

Do you think your child needs additional support in school? _____ If so, explain: _____
_____
_____
_____

BIRTH/MEDICAL HISTORY

Were there problems during the pregnancy, labor, or delivery? _____ If so, explain: _____
_____

How many weeks or months was the pregnancy? _____ Baby's birth weight: _____

Birth was (check one): ☐ Normal ☐ Cesarean ☐ Breech ☐ Twins or more

Did baby have problems after birth? _____ If yes, please explain: _____
_____

Please list any major illnesses or injuries your child has had to this date: _____
_____

Is your child taking any medications regularly? _____ If yes, please list: _____
_____

Child's Primary Care Physician (Name/Address/Phone): _____
_____

List any other doctors/evaluators who have treated your child (Include name/address/phone): _____
_____
_____

Has your child ever been hospitalized? _____ If so, where? _____
Reason for hospitalization? _____
_____

DEVELOPMENTAL HISTORY

At what age did your child roll over _____ Sit Alone _____ Pull up to furniture _____ Crawl _____ Walk _____
Say Single Words _____ Say 3-word sentences _____ Become Toilet Trained _____

Amos Cottage TDP Outpatient Therapy Clinic
Admission Assessment

PLEASE CHECK THE AREAS THAT CURRENTLY CONCERN YOU ABOUT YOUR CHILD

GROSS MOTOR SKILLS:
☐Running ☐ Climbing unassisted ☐ Pedaling a tricycle ☐ Jumping with good balance ☐ Using stairs alternating feet ☐ Balancing on one foot ☐ Kicking a ball ☐ Throwing a ball overhead ☐ Sliding unassisted

FINE MOTOR SKILLS:
☐ Holding a pencil ☐ Copying (lines/circles) ☐ Using scissors ☐ Opening wrappers

SELF-HELP SKILLS:
☐ Using both spoon/fork ☐ Toileting independently ☐ Undressing independently ☐ Dressing independently ☐ Washing/Drying hands independently

STRENGTH AND MUSCLE TONE:
☐ Loses balance ☐ Clumsy ☐ Can't hold sitting position on floor for 5 minutes ☐ Muscles too tight ☐Muscles too loose

SENSITIVITIES:
☐ Avoids certain clothing items ☐ Avoids certain foods/smells ☐Picky eater ☐ Wears clothes incorrectly ☐ Becomes frightened when feet leave the ground ☐ Avoids going barefoot ☐ Bothered by certain noises (specify noise): _____

SEEKS SENSATION:
☐ Chews clothes ☐ Enjoys/Makes strange noises ☐ Can't sit still/Fidgets ☐ Becomes overly excited during activities ☐ Touches people/objects ☐ Doesn't notice when hands/face are messy

LISTENING SKILLS:
☐ Hears what is being said ☐ Difficulty paying attention ☐ Easily distracted by noise in immediate setting

COGNITIVE LEARNING:
☐ Understanding positive/negative consequences ☐ Following/understanding rules ☐ Stops and thinks before acting ☐ Learns new concepts ☐ Remembering what they have learned ☐ Distinguishing between reality/fantasy (understands what is real and what is pretend

ATTENTION/ACTIVITY LEVEL:
☐ Overly Active ☐ Low energy/underactive ☐ Appears in own world ☐ Short attention span

SOCIAL/EMOTIONAL:
☐ Expressing feelings verbally: ☐ Happy ☐ Sad ☐ Angry ☐ Afraid
☐ Naming/Identifying a friend ☐ Limited range of activities/toys ☐ Odd/Intense interests ☐ Engaging in cooperative play ☐ Engaging in imaginary/pretend play ☐ Little interest in peers ☐ Little interest in adults

OTHER:
☐ Accepts transitions ☐ Insists on routines ☐ Difficulty separating from family members ☐ Repeats questions when answers are provided ☐ Appears worried ☐ Often complains of not feeling well ☐ Likes things a certain way ☐ Does not like when play items are moved ☐ Speaks less in group settings ☐ Often appears irritable ☐ Mood changes frequently ☐ Unaware of danger ☐ Sleep problems

Amos Cottage TDP Outpatient Therapy Clinic
Admission Assessment

REFERRAL CONCERNS:

What are your primary concerns about your child? _____
_____

What have you been told regarding these concerns? (by your child's doctor, etc.) _____
_____
_____

Has your child received a behavioral or medical diagnoses? _____ If yes, please note: _____
_____
_____

What would you like to see done for your child during counseling? _____
_____
_____
_____

How can this program support you as a parent/caregiver? _____
_____
_____
_____

Who referred you to the Outpatient Therapy Clinic? _____

Name of person completing this form: _____

I do hereby give my permission, as this child's parent/guardian, to have him/her treated/evaluated by the Amos Cottage Therapeutic Day Treatment Outpatient Therapy Team. I understand that this facility is both a service and a training program and give my consent to have fully-supervised students participate in the evaluation.

Parent/Guardian (Print Name): _____

Signature: _____ Date: _____

Please return completed forms to the TDP Outpatient Therapy Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).

WAKE FOREST BAPTIST HEALTH

For a list of entities covered by this form please see
www.wakehealth.edu/compliance/Notice-of-Privacy-Practices.htm.

For Office Use Only: MRN: _____
Date Rec'd _____ Date Sent _____

Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(patient name & date of birth)

To be Released From/By: (Primary Care Provider)
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway
(Address of authorized recipient of information)

Winston-Salem, NC 27103 (City/State/Zip) 336-713-7497 Phone Number 336-702-9199 Fax Number

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

- ☐ Emergency Department
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Office/Clinic Note
- ☐ Radiology result
- ☐ Cardiac Catheterization
- ☐ Pathology report
- ☐ Lab result
- ☐ Other specific (please list): _____
- ☐ Entire visit (provider notes, results, flowsheets/nursing notes, scanned documents, etc.)

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ _____ to _____

Please provide the **treatment location** (specific hospital, or physician practice location, department): _____

The information will be used/disclosed for the following **purpose:**

☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ Paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ☐pickup ☐MyChart (if available, appropriate) ☐ Other: _____

- I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.
- I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient
(written proof may be required)

This release is limited to the Facility/Practice or Department **you specified above.**

To obtain information from another Facility/Practice or Department individual authorizations will be needed.

Please contact the specific department or WFBH HIM Department at (336) 716-3230 with questions.

WAKE FOREST BAPTIST HEALTH
For a list of entities covered by this form please see
www.wakehealth.edu/compliance/Notice-of-Privacy-Practices.htm.

For Office Use Only: MRN: _____
Date Rec'd _____ Date Sent _____

Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(patient name & date of birth)

To be Released From/By: _____ (Daycare/School)
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

_____
(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway
(Address of authorized recipient of information)

Winston-Salem, NC 27103 (*City/State/Zip*) 336-713-7497 (*Phone Number*) 336-702-9199 (*Fax Number*)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

- ☐ Emergency Department
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Office/Clinic Note
- ☐ Radiology result
- ☐ Cardiac Catheterization
- ☐ Pathology report
- ☐ Lab result
- ☐ Other specific (please list): _____
- ☐ Entire visit (provider notes, results, flowsheets/nursing notes, scanned documents, etc.)

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ _____ to _____

Please provide the **treatment location** (specific hospital, or physician practice location, department): _____

The information will be used/disclosed for the following **purpose:**

☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ Paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ☐pickup ☐MyChart (if available, appropriate) ☐ Other: _____

- I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.
- I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient
(written proof may be required)

This release is limited to the Facility/Practice or Department **you specified above.**

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Please contact the specific department or WFBH HIM Department at (336) 716-3230 with questions.

Amos Cottage Outpatient Therapy Clinic

Financial Coverage (please complete)

Clients Name: _____ **Date of Birth:** _____

Social Security Number: _____

1. Is client covered by any private insurance? _____

   POLICY #1
   Policy holders Name: _____

   Employer: _____

   Insurance company (name/address/phone): _____

   _____

   Policy Number: _____ **I.D. Number:** _____

   Group Number: _____ **Claims Address/Phone:** _____

   _____

   POLICY #2
   Policy holders Name: _____

   Employer: _____

   Insurance company (name/address/phone): _____

   _____

   Policy Number: _____ **I.D. Number:** _____

   Group Number: _____ **Claims Address/Phone:** _____

   _____

2. Is client covered by **Medicaid**? _____ Medicaid #: _____

3. Is client covered by **NC HealthChoice**? _____ NC HealthChoice #: _____

Please return completed forms to the TDP Outpatient Therapy Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program

Amos Cottage/United Way
Request for Financial Assistance for Therapeutic Day Program Outpatient Therapy

Client's Name: _____
Parent/Guardian Name: _____
Number of people in immediate family: _____
Home Address: _____
Home Phone Number: _____ Work Phone Number: _____
Immediate family members in client's household:

Name	Relationship to client

List all employers or source of income/Reason for none for 12-month period	Dates from	To	Yearly Gross Income	Yearly Income after Tax	Documented
		Total gross family income			
		Fed, state & SS Tax			
		Income after Taxes:			

Total amount after taxes: _____

Eligibility for other programs ***(check all that apply)***
SSI: _____ Medicaid: _____ Medicaid #: _____
Eligibility Date: _____

Please complete the entire form; partial completion of form can delay the admission process

Applicant's signature: _____ Date: _____

Relationship to client: _____

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Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program Outpatient Therapy
School Information Request

(To be completed by school or daycare staff)

Child's Name: _____ Student/School number: _____

Dear Teacher:

The parent/guardians of the above-named child are interested in admitting their child to the Therapeutic Day Program at Amos Cottage with Atrium Health Wake Forest Baptist. Your responses to the following questions are an essential component to the evaluation for admission and will be greatly appreciated.

A. Basic Information

1. School name, address, phone: _____
   _____
2. Hours of attendance: _____ Teacher Name: _____
3. Number of students in class: _____ Age Range/Grade: _____
4. Number of adults (teachers, aides, volunteers) available for supervision of these children? _____
5. Does this child have an active IEP in place? _____ (If the child has an IEP the program will need a copy of the plan prior to admission)
6. What concerns do you have of this child at this present time? Please list in order of concern.
   1) _____
   2) _____
   3) _____
   4) _____

Was an IST referral initiated? _____ (Please provide a copy of any referrals made to the IST Team)

For School Age Children, the following documentation/plans will need to be provided to the program to further support admission.

What interventions have been implemented to address the above noted behaviors and found unsuccessful (e.g., **Functional behavioral Assessment, Functional Behavioral Plan, Individualized Education Plan, 504 Plan, Behavior Plans)?** _____

_____

_____

Please provide the program a copy of these interventions verifying implementation along with this document. (Note comments here)

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program Outpatient Therapy
School Information Request

(To be completed by school or daycare staff)

For Pre-school age children the program will need documentation detailing specific behavioral interventions that were implemented and found unsuccessful. This documentation is needed to further support admission. These may include interventions suggested by the 'Behavioral Specialist'/Work Family Resource/Smart Start. Please provide the program a copy of these interventions verifying implementation or note the interventions here: _____

_____

_____

What contact have you had with the parents? _____

Has the child received a developmental evaluation? _____

(If yes, who performed the evaluation? _____

Please **check** the areas of **currently concern:**

Gross Motor Skills:

☐Running ☐ Climbing unassisted ☐ Pedaling a tricycle ☐ Jumping with good balance ☐ Using stairs alternating feet ☐ Balancing on one foot ☐ Kicking a ball ☐ Throwing a ball overhead ☐ Sliding unassisted

Fine Motor Skills:

☐ Holding a pencil ☐ Copying (lines/circles) ☐ Using scissors ☐ Opening wrappers

Self-Help Skills:

☐ Using both spoon/fork ☐ Toileting independently ☐ Undressing independently ☐ Dressing independently ☐ Washing/Drying hands independently

Strength and Muscle Tone:

☐ Loses balance ☐ Clumsy ☐ Can't hold sitting position on floor for 5 minutes ☐ Muscles too tight ☐Muscles too loose

Sensitivities:

☐ Avoids certain clothing items ☐ Avoids certain foods/smells ☐Picky eater ☐ Wears clothes incorrectly ☐ Becomes frightened when feet leave the ground ☐ Avoids going barefoot ☐ Bothered by certain noises (specify noise): _____

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program Outpatient Therapy
School Information Request

(To be completed by school or daycare staff)

Please **check** the areas of **current concern**:

Seeks Sensation:

☐ Chews clothes ☐ Enjoys/Makes strange noises ☐ Can't sit still/Fidgets ☐ Becomes overly excited during activities ☐ Touches people/objects ☐ Doesn't notice when hands/face are messy

Listening Skills:

☐ Hears what is being said ☐ Difficulty paying attention ☐ Easily distracted by noise in immediate setting

Cognitive Learning:

☐ Understanding positive/negative consequences ☐ Following/understanding rules ☐ Stops and thinks before acting ☐ Learns new concepts ☐ Remembering what they have learned ☐ Distinguishing between reality/fantasy (understands what is real and what is pretend

Attention/Activity level:

☐ Overly Active ☐ Low energy/underactive ☐ Appears in own world ☐ Short attention span

Social/Emotional:

☐ Expressing feelings verbally: ☐ Happy ☐ Sad ☐ Angry ☐ Afraid
☐ Naming/Identifying a friend ☐ Limited range of activities/toys ☐ Odd/Intense interests ☐ Engaging in cooperative play ☐ Engaging in imaginary/pretend play ☐ Little interest in peers ☐ Little interest in adults

Other:

☐ Accepts transitions ☐ Insists on routines ☐ Difficulty separating from family members ☐ Repeats questions when answers are provided ☐ Appears worried ☐ Often complains of not feeling well ☐ Likes things a certain way ☐ Does not like when play items are moved ☐ Speaks less in group settings ☐ Often appears irritable ☐ Mood changes frequently ☐ Unaware of danger ☐ Sleep problems

Comments:

_____
_____
_____
_____
_____

Signature: _____ Date: _____

Title: _____

Please return completed forms to the TDP Program Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program Outpatient Therapy
School Behavior Intervention Plan

Program/Facility Name: _____

Child/Student Name: _____

Name/Title of Person Completing Plan Form: _____

Describe Problem Behavior(s):

Problem Behavior (*Aggression, Disrupting Class, Elopement/Running from Room)*	**How Often/Frequency**	**How Long/Duration**	**Data** *(Include collection methods/source dates)*
1.			
2.			
3.			

a) **Antecedent** *(summarize what happens BEFORE each identified behavior)*

___ Lack of Social Attention ___ Demand Request ____ Difficult Task ____ Transition

____ Interruption/Change in Routine _____ Consequences Imposed

____ Other/Describe _____

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program Outpatient Therapy
School Behavior Intervention Plan

Describe Behavioral Interventions Used: (Proximity to Teacher/Reward Program; Modified – Shortened Day: 1:1 Instruction/Attention…)

_____
_____
_____
_____
_____

Describe Child's Current Response to Interventions Used:

_____
_____
_____
_____
_____

Summary Statement: General Impression of Behavior; why would this child benefit from a therapeutic setting.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Contact Amos Cottage Therapeutic Day Program with any questions regarding the completion of this form: Intake Specialist (336-713-7493 or Program Director (336-713-7443)

Please return completed forms to the TDP Program Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).