



Breckenridge, CO

Dear Prospective Clients and Families,

You have likely reached out because you have had a different experience than others. Your child or a loved one is amazing, and either not everyone gets to experience it, or those moments are brief and inconsistent. You've been trying, and want things to get even better. While I never want anyone to have a difficult time, I am glad that your experiences have led you to Blue Skies, where we may be able to embark on a new journey together.

Established in Summit County, Colorado, Blue Skies Behavioral Group aims to support the children, families, and communities both in and surrounding our beautiful ski country. At Blue Skies, we work together to make child-centered changes that empower and improve the lives of all our families. We want to push through any clouds, turbulence, and bad weather to arrive in a space where continued growth has no limit.

Whether you are new, or long involved in the world of Applied Behavior Analysis (ABA), there may have been many different ways you've gotten here, along with different ideas, anecdotes, and stories you've gathered along the way. At Blue Skies we emphasize the child, and not only honor what makes them unique, but makes them *them*. We will not "fix" a child, but help them to learn how to be *themselves* in a neurodiverse world. We celebrate differences, and teach skills to make those differences be the reason that someone may both stand out and fit in at the same time. And we will do this all together.

Thank you for considering Blue Skies Behavioral Group to help with your child's needs. Please reach out with any questions you may have either now, or on the way. The following information will be used to initiate the process to establish services. Let's get to Blue Skies, Together.

*Sincerely,*

***Kyle Kahnweiler***

Founder, Director, Board Certified Behavior Analyst  
***Blue Skies Behavioral Group***



***Declaration of Practices and Procedures***  
**Blue Skies Behavioral Group**

Kyle Kahnweiler, Master of Education  
Board Certified Behavior Analyst

**For My Prospective Clients and Client's Family**

*This document has been written to inform you on my background, practices, and procedures to outline our professional relationship.*

**About Blue Skies Behavioral Group and Applied Behavior Analysis**

Applied Behavioral Analysis (ABA) is a scientific field that has been deemed a medically necessary intervention for individuals with Autism, and has been shown to be impactful for individuals with developmental disabilities and individuals with additional needs. *Applied* means that the practice intervenes in areas that matter. *Behavior* is working with actions and outcomes that are observable and measurable. *Analysis* is using scientific methods and data to guide interventions. ABA interventions involve assessment, observation, creating intervention based on need, teaching new skills, and transferring all progress to an individual's naturally occurring environment.

**Areas of Expertise**

I have been a practicing Board Certified Behavior Analyst (BCBA) since July of 2018. I obtained my undergraduate degree in Severe Needs Special Education from Vanderbilt University. Following graduation, I stayed at Vanderbilt's Peabody College to pursue my Masters of Education in Mild and Moderate Special Education, where I became an Intervention Specialist and completed my supervision and internship requirements to obtain my Behavior Analyst Board Certification. Following my move to Breckenridge, Colorado, I worked jointly as an elementary Severe Needs Special Education teacher and District BCBA.

As a result of my studies that included working with students aged 3-21 across a wide spectrum of abilities, my professional and supervised opportunities in clinics and home settings, as well as my work in the school district, my areas of expertise range from intensive behavioral intervention upwards to individuals who have less severe needs. Individuals I work with include, but are not limited to, those who engage in severe and moderate aggression, self injurious behavior, demonstrate difficulty in communication, and following directions. I work with caregivers, multidisciplinary teams, parents, and children, ranging from early intervention to 21

years of age. I specialize in working with individuals with Autism Spectrum Disorder, Downs Syndrome, and individuals with multiple and severe needs.

### **Professional Relationship, Limitations, and Risks**

#### *What we do.*

Applied Behavior Analysis is a method of treatment that is based on the idea that *all behaviors serve a purpose*, and these behaviors have been *learned* and *reinforced* in their environments. My job as a behavior analyst is to work with you to identify strengths and areas of treatment, and together, create ways to help everyone be successful in their environments. We will conduct interviews, observations, and assessments to identify the purpose (or function) of behaviors and create an individualized and unique plan that will lead to skill acquisition and improvement for the client and everyone in their immediate surroundings.

#### *How We Work.*

As a behavior analyst, we do not make any judgements on behaviors or the systems that surround them. To us, nothing is good or bad, but rather functional or not. We make changes accordingly to the individuals we work with to decrease any pain, suffering, or anxiety, and increase overall success and happiness for our clients and those they are most often surrounded by.

We will not be working alone. We will rely on family members and caregivers to participate throughout the process. Participation will include honest communication on how things are going: if things are not working, we will make changes. You will be consulted throughout the entirety of the process. Together we will come up with goals, we will share data and assessment results, plan for intervention, and ask for your approval. We're in this together! Any success is *our* success!

Please know that we cannot guarantee any specific outcomes. However, together we can get closer and closer to our goals each time we meet. If we believe that at any points our sessions become unproductive, we will discuss terminating therapy and providing referral information for a transition. If at any point you want to terminate our relationship, we will cooperate fully.



Client Initials:

**Authorization to Release and Obtain Information**

The purpose for the obtaining and/or release of information is to help achieve the best possible therapeutic outcomes, which may involve collaborating with additional team members who work with you/your child, and may include but not be limited to other related syndromes, diseases, psychiatric or psychological conditions, test results, assessments, progress reports, treatment plans, therapy, and non-medical information.

Client Information:

Name:	DOB:	
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I authorize **Blue Skies Behavioral Group** to *obtain* and *release* protected information with the following organization(s) (which may include healthcare providers, insurance, employer/school, government agencies, clinics):

	Provider Name	Therapy Type	Address	Contact Information
1				
2				
3				
4				
5				

This permission shall be valid beginning on the date that this is signed by client/parent/guardian until the date that consent is revoked in writing. All releases of information must be renewed every 12 months. By signing, you acknowledge that you understand that consent is voluntary and may be revoked at any time in writing.

**I hereby authorize the transfer of information as indicated above.**

\_\_\_\_\_

## Initial Intake Information

Client Intake Information		
<b>Name of person filling out form:</b>	<b>Relation to child / client:</b>	<b>Date form is completed:</b>

Child Information	
<b>Last Name:</b>	<b>Date of Birth:</b>
<b>First Name:</b>	<b>Age: ____ Years ____ Months</b>
<b>Address (Primary):</b> _____	<b>Address (Secondary):</b> _____
<b>State:</b> _____ <b>Zip:</b> _____	<b>State:</b> _____ <b>Zip:</b> _____
<b>County:</b> _____	<b>County:</b> _____
<b>Gender:</b>	<b>Race / Ethnicity:</b>

<b><u>Diagnosis History:</u> Please indicate any medical diagnoses your child has, who the identifying doctor was, date, and if a copy of the report is attached. If an appointment is scheduled for the future, please indicate below.</b>			
Diagnosis (Autism, speech delay, ADHD, etc...)	Diagnosing Doctor	Date (of past or future appt)	Check if report attached



Client Initials:


<b>Mother or Legal Guardian Information</b>
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**Full Name:**

**Address (if different from child):**

\_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Date of Birth:**

**Home Phone:**

**Email:**

**Cell Phone:**

**Occupation/ Employer:**

**Business Phone:**

*I agree to be contacted by Blue Skies Behavioral Group and their partners in the following methods to communicate private health information and treatment information:*

Email Yes No	Home Phone Yes No	Cell Phone Yes No	Business Phone Yes No
Place check in box if OK to leave a message:			

Client Initials: \_\_\_\_\_

Signature: _____	Date: _____
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**Father or Legal Guardian Information**

**Full Name:** \_\_\_\_\_

**Address (if different from child):**  
\_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **County:** \_\_\_\_\_

<b>Date of Birth:</b> _____	<b>Home Phone:</b> _____
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<b>Email:</b> _____	<b>Cell Phone:</b> _____
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<b>Occupation/ Employer:</b> _____	<b>Business Phone:</b> _____
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*I agree to be contacted by Blue Skies Behavioral Group and their partners in the following methods to communicate private health information and treatment information:*

Email Yes No	Home Phone Yes No	Cell Phone Yes No	Business Phone Yes No
<b>Place a check in box if OK to leave a message:</b>			

Signature: _____ 	Date: _____
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**Additional Legal Guardian Information**

Client Initials: \_\_\_\_\_

<b>Full Name:</b>			
<b>Address (if different from child):</b> _____			
State: _____ Zip: _____ County: _____			
<b>Date of Birth:</b>		<b>Home Phone:</b>	
<b>Email:</b>		<b>Cell Phone:</b>	
<b>Occupation/ Employer:</b>		<b>Business Phone:</b>	
<i>I agree to be contacted by Blue Skies Behavioral Group and their partners in the following methods to communicate private health information and treatment information:</i>			
<b>Email</b> Yes   No	<b>Home Phone</b> Yes   No	<b>Cell Phone</b> Yes   No	<b>Business Phone</b> Yes   No
<b>Place check in box if OK to leave a message:</b>			
<b>Signature:</b> _____		<b>Date:</b> _____	

Other People Living in Home			
Name	Age	Relation	Gender

Client Initials:


**Significant Non-Family Members**

Name	Age	Relation	Gender

**Pets Living in the Home**

Name	Age	Type	Gender

**Emergency Contact**

<b>Name:</b>	<b>Phone 1:</b>
<b>Relation:</b>	<b>Phone 2:</b>

**By signing, I agree for Blue Skies Behavioral Group to contact the emergency contact provided in the event of an emergency and parents or guardians are not available.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Client Initials:

<b>Additional Client Information</b>				
<b>Known Allergies:</b> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>		<b>Dietary Restrictions:</b> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>		
<b>Medications</b>				
Medication	Dosage	When Given	Used For:	Prescribed By:

Client Initials: \_\_\_\_\_

School Information	
<b>Current School:</b>	<b>Grade:</b>
<b>Does child have IEP?</b> <b>Yes</b> <b>No</b>	<b>If yes, check if copy of IEP is provided:</b> <b>Yes</b> <b>No</b>
<b>Educational Primary Disability:</b>	<b>Educational Secondary Disability:</b>
<b>Case Manager Name:</b>	<b>Case Manager Email:</b>
<b>School Services (i.e. Speech, OT...)</b>	<b>Provider Name:</b>
1.	
2.	
3.	
4.	
5.	

Client Preferences
<i>Please indicate any information any providers should know about working with client.</i>
<b>Preferences (favorite activities, foods, toys, etc...)</b>
_____
_____
_____

Client Initials:

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**Dislikes (demands, ending activities, etc...)**

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**Other:**

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**Areas of Concern**

<b>Behavior (Please Describe)</b>	<b><u>Frequency</u></b> (hourly, daily, weekly, etc..)	<b><u>Duration</u></b> (how long it lasts)	<b><u>Severity</u></b> 1- Noticeable but not dangerous 2-potential to cause mild harm 3- significant harm possible

Client Initials: \_\_\_\_\_

Behavior	What happens RIGHT BEFORE?	What happens RIGHT AFTER?	<i>WHO</i> it is most likely to occur with?

Client Skills: Expressive Communication			
Child Uses an Augmented or Alternative Communication (AAC) or Speech Generating Device	Yes	No	
Child can form intelligible words	Always	Sometimes	Never
Please describe (if limited, roughly how many?):			
Child communicates wants / needs	Always	Sometimes	Never
Please describe:			
Child can request specific items	Always	Sometimes	Never
Please describe:			
Child can request help	Always	Sometimes	Never
Please describe:			

Client Initials:

Child can imitate vocal sounds, words, and phrases	Always	Sometimes	Never
Please describe:			
Child can label items, events, or actions	Always	Sometimes	Never
Please describe:			
Child can answer questions	Always	Sometimes	Never
Please describe:			
Receptive Communication			
Child can follow single or multi-step directions	Always	Sometimes	Never
Please describe:			
Child can follow/engage in specific routines (ex. Bedtime, breakfast, etc...)	Always	Sometimes	Never
Please describe:			
Child can select an item from multiple choices (ex. "Which one is the spoon?")	Always	Sometimes	Never
Please describe:			
Play Skills			

Client Initials:

Child seeks attention of others	Always	Sometimes	Never
Please describe (who?):			
Child plays with toys as they are intended (ex. A toy car "drives")	Always	Sometimes	Never
Please describe:			
Child plays with a wide variety of toys	Always	Sometimes	Never
Please describe:			
Child will engage with other children	Always	Sometimes	Never
Please describe:			
Child will engage in imaginative/pretend play	Always	Sometimes	Never
Please describe:			
<b>Independent Living Skills</b>			
Child can feed themselves independently	Always	Sometimes	Never
Please describe:			
Child can dress themselves independently	Always	Sometimes	Never
Please describe:			

Client Initials:

Child can toilet themselves independently	Always	Sometimes	Never
Please describe:			
Executive Functioning			
Child shows rigidity or resistance to change / transitions	Always	Sometimes	Never
Please describe:			
Child fixates / perseverates on specific topics / items	Always	Sometimes	Never
Please describe (who?):			
Child can be independent in tasks	Always	Sometimes	Never
Please describe:			
Child engages in independent leisure skills	Always	Sometimes	Never
Please describe:			

Areas for Immediate Attention
If we could help improve 3 areas of your life immediately, they would be:
1. _____

Client Initials:

2.	
3.	

Additional Information We Should Know About Your Child
Please describe:

Hours for availability for ABA services are (please check all that apply):						
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 AM						
9:00 AM						
10:00 AM						
11:00 AM						
12:00 PM						
1:00 PM						
2:00 PM						
3:00 PM						
4:00 PM						
5:00 PM						
6:00 PM						