



Service(s) Request

Child's Name: _____ DOB: _____

Child's Current School: _____ Child's Current Grade: _____

Parent/Guardian Name: _____ Phone: _____ Email: _____

SCHOOL SERVICES

Must select payment method

Table with 4 columns: SERVICE TYPE, MONTHLY TUITION, COMMENTS. Rows include Full time student, Modified school day, and 1:1 Classroom Aide.

*Only available if child is also receiving daily clinic-based ABA therapy at ABC of NC

I plan to pay out of pocket for school services I plan to apply for financial assistance for school tuition support

CLINICAL SERVICES

Rates effective 10/1/2021

May be covered through private health insurance and/or Medicaid and subject to co-pays or co-insurance

Table with 4 columns: SERVICE TYPE, RATE, COMMENTS. Rows include 1:1 Applied Behavior Analysis (ABA) Therapy and Individual and Family Counseling/Psychotherapy.

SUPPLEMENTAL SERVICES

Table with 4 columns: SERVICE TYPE, RATE, COMMENTS. Rows include School Consultation (off-site) and Service Recommendation Visit.

SERVICES- TYPICALLY DEVELOPING PEERS

Table with 4 columns: SERVICE TYPE, MONTHLY TUITION, COMMENTS. Rows include Preschool and Readiness.

SIGNATURE OF PARENT/GUARDIAN

DATE SUBMITTED

This is a request form only and not a guarantee of services. This form is not a replacement for any required financial aid/ scholarship applications, insurance company or other funders' requirements.

Return completed form to: Leigh Ellen Spencer leighellen.spencer@abcofnc.org