



Creative Potential, LLC
912 Norwich New London Turnpike,
Unit #5, Uncasville, CT 06382
p-(860)848-0514, f-(860)-848-0523
www.Creativepotentialllc.com

Hello ABA Providers and Families,

Thank you for your interest in our Autism Behavior Analysis program. Below is the information needed to add your individual to our list for immediate enrollment or our waitlist status is pending both clinician and family availability. Once this information is received a person from our administrative team will contact you with your status.

Thank You!

ABA Therapy Referral Form

Client Name: _____ DOB: _____ Language: _____

1st Insurance Carrier: _____ Id# _____

2nd Insurance Carrier: _____ Id# _____

Parent/ Guardian name _____ Phone _____

Parent/ guardian email: _____

Home Address: _____

City: _____ State: _____

Date of Diagnostic Evaluation: _____ Completed by: _____

Requested Service Start Date: _____

Referring person's/agency name: _____ Relationship to child _____

Phone #: _____ Cell phone #: _____ Email: _____

Please fill out a referral for each individual service and child requested. Once complete, email the document(s) to **INFO@CREATIVEPOTENTIALLLC.COM** or faxed to us at 860-848-0523. Thank You!



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FAMILY AVAILABILITY FOR SERVICES: (start time -end time)
 Services are not rendered on Sundays.

	School Year Approx. Sept- Mid-June:		Summer Approx. Mid-June -August	
Monday	Start:	End:	Start:	End:
Tuesday	Start:	End:	Start:	End:
Wednesday	Start:	End:	Start:	End:
Thursday	Start:	End:	Start:	End:
Friday	Start:	End:	Start:	End:
Saturday	Start:	End:	Start:	End:

To streamline intake when available please be prepared to have the following documents read in PDF format.

PLEASE DO NOT SUBMIT THE FOLLOWING DOCUMENTS NOW, THIS IS FOR INFORMATION PURPOSES ONLY.

Please submit to have the following when requested by administration:

- Child’s social security card
- Child’s birth certificate
- ROI for school, doctors and other treating providers filled out (ROI’s can be found on our website)
- Last 3 IEP’s
- Autism Evaluation
- Support letter of diagnosis from pediatrician If diagnosis is greater than one year.

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