Shine Your Star
aba@shineyourstar.net

Phone# 978-891-4740
Fax# 978-529-8278

Service Request Form

_____ _____ _____

Client (Child's Full Name) Gender DOB

_____

Diagnosis

_____ ☐ Secondary Insurance

Insurance Number

Insurance Subscriber

_____ _____

Name DOB

_____ _____

Type of Insurance Subscriber's Insurance Number

Parent/Guardian 1 Relationship to Client

Address

City State Zip Code

Phone Number Email

Parent/Guardian 2 Relationship to Client

Address

City State Zip Code

Phone Number Email

Preferred location services:

☐ In-home (Northern Merrimack Valley Region)

☐ Clinic (200 Washington St, Boxford, MA)

Please indicate in the space below the available times for ABA services. Make sure to specify if it is AM or PM.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

The following documents are required.

- Please attach documentation of autism spectrum disorder signed by a licensed physician or licensed psychologist.

- Please attach a copy of the child's insurance card (front and back).

- If your child has a secondary insurance, please include a copy of that insurance card as well (front and back)