



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Parent Handbook

Right to Participate in Child’s Therapy Sessions

Developmental Enhancement, (DE), has an open-door policy for parents and guardians. Parents/guardians have the right to participate in therapy sessions. In fact, DE believes that parents are a critical part to their child’s development and encourages parents to be a part of their child’s treatment sessions. However, if parents believe they are hindering their child’s progress or are distracting to their child by participating in sessions, they are encouraged to talk to the BCBA about other ways to be involved or to decrease the frequency in which they participate. Sibling observation can either add or take away from therapy sessions; please talk to the BCBA as to whether this is appropriate and recommended. All clinical questions should also be directed to the BCBA rather than the technician.

I am fully aware of my right to participate in sessions and understand that it is my choice to participate in other BCBA approved ways if I feel my presence hinders my child’s learning progress.

Parent/Guardian Signature

Date

Right to Give your Consent and the Right to Refuse the Use of Video Recording

I give my permission for _____ to:
Child’s Name

- Be video/ digitally recorded for internal office use including use of supervision, learning processes/ shadowing, etc.
- Be video/digitally recorded for parent/guardian use if physically participating in the child’s sessions are distracting for my child. (If parents feel it is a distraction to participate in their child’s therapy sessions, they give DE permission to video tape their child’s sessions and have the right to view these videos for later use and learning experiences.)

Parent/Guardian Signature

Date

Parents/ guardians are required to let the BCBA, if available, or technician know if you would like to take a picture of your child during a session. Please refrain from taking pictures/video without permission in order to ensure other client’s confidentiality.



DEVELOPMENTAL ENHANCEMENT BEHAVIORAL HEALTH

W// debh.org

1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

- Missing 35-40% of appointments within a 4-week time frame: You will be contacted and reminded of your agreed upon treatment schedule. A modification to the schedule may be made.
- Missing 50% or greater of appointments within a 6-week time frame: You will be contacted and reminded of your agreed upon treatment schedule. If necessary, discontinuation of services may occur.

Unreported absences of three consecutive no shows/no calls will generally be considered a voluntary termination of services.

Late for appointment (Not due to weather):

- Late for 25% of appointments within a 2-week time frame: You will be contacted and reminded of your agreed upon treatment schedule. Discussions may include a change in scheduling if necessary to ensure consistency.
- Late for 35-40% of appointments within a 4-week time frame: You will be contacted and reminded of your agreed upon treatment schedule. A modification to the schedule may be made.
- Late for 50% or greater appointments within a 6-week time frame: You will be contacted and reminded of your agreed upon treatment schedule. Formal meeting will be coordinated to discuss the parents and DE's concerns.
- Late for additional appointments after formal meeting is held: Discontinue services

Cancellations: If being late or missing the appointment is unavoidable, please be courteous and call to notify the receptionist as soon as possible (not due to extreme weather or sickness). Many of our staff drive long distances in bad weather in order to be on time. Please give notice of any planned vacations, appointments, etc. at least 48 hours in advance and 24-hour notice if possible for sickness.

ABA Contact Guide When Late Arrivals are Unavoidable

1. Contact the Receptionist (phone numbers for each location are available on each page)
2. If not able to reach the Receptionist, contact the Behavior Technician
3. If not able to reach the Behavior Technician, contact the supervising BCBA

Inclement Weather Policy

Should inclement weather conditions arise that would make it unsafe to continue hours of operation at the office, the director may elect to close the office (i.e., cancel appointments and suspend all existing appointments). If such conditions are expected, please call the office to confirm appointment. Notice of closure may be found on our Facebook page at: [Facebook.com/DEBHclinics](https://www.facebook.com/DEBHclinics)

Parent/Guardian Signature

Date



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

General Hours of Operation

Monday-Friday 8:00 – 6:00 (evening appointments specific to therapist). The office is closed for New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas.

Emergencies

A copy of our fire, tornado, and intruder plans are in each suite as well as in the waiting room as a parent reference. Please take a moment to become familiar with these plans and ask DE staff if you are unable to find them. In case of an emergency, the parent/guardian will be called. If DE is unable to reach the parent/guardian, we will contact the emergency contact listed.

Parking

Since parking is limited we request that those who stay to observe sessions park further away to ensure closer parking spots are available for parents dropping clients off or parents with small children. We appreciate your cooperation and thank you in advance.

Gift Giving

While we are grateful for your appreciation, per our ethical and compliance code, our team cannot accept any gifts. Entrusting us to work with your child is all the gratitude/gift we need! If you would like to demonstrate your gratitude for Developmental Enhancement, we ask that any gift giving be made to Family Hope Foundation. Their scholarships allow many families at Developmental Enhancement to receive therapy.

Change of Clothing/Diapers

Please send a change of clothing, diapers, and wipes if applicable. For clients who are potty-training or have frequent accidents, please make sure to provide extra sets of clothing to ensure enough dry clothing throughout the day.

Meals/Snacks

In such cases when your child attends therapy for an extended period of time, please be sure to pack a snack, something to drink, and a lunch if applicable.

Service Animal Policy

No animals are permitted on premises unless the owner shows that the animal is a trained service animal. A “service animal” is defined as a dog that has been individually trained to do work or perform tasks for an individual with a disability. The tasks performed by the dog must be directly related to the person’s disability. A dog does not qualify as a service dog if the purpose is solely to provide comfort to the handler. The handler may be asked whether the service animal is required due to disability and what work the service animal is trained to perform. The person with a disability is responsible for the dog and any damages as a result of the dog’s actions. The service animal must be controlled by the handler at all times. If the service animal is behaving in a threatening manner, repeatedly barking, or has a history of violence, the animal may be excluded. The service animal must be housebroken and on its leash at all times.

I understand and agree to abide by all Developmental Enhancement protocols listed above.

Parent/Guardian Signature

Date



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Confidentiality Agreement- Waiting Room & Shared Treatment Spaces

Client confidentiality is a priority at Developmental Enhancement which is why parents are required to sign our confidentiality agreement if they sit in on client sessions. However, the BCBA's and Behavior Technicians may discuss client sessions with parents in the waiting room after each session while other clients and parents are present. Although we can increase client confidentiality by requiring parents/guardians to sign the confidentiality agreement, we cannot guarantee that others will not overhear client information that is discussed between parents and DE staff.

I acknowledge that Developmental Enhancement cannot guarantee that session updates and discussions won't be overheard by other clients and parents while in the waiting room. I understand this potential risk and would still like to be informed, in the waiting room, on any updates after a session.

Yes No

While in any area utilized by Developmental Enhancement, PLC, both clients and family members of clients agree not to divulge any confidential information which comes to them in relation to any other client or family member of another client at Developmental Enhancement. This shall include:

- Not discussing any information pertaining to any other client or family member of a client with anyone including but not limited to, my own family, friends, or relatives.
- Not discussing any information pertaining to any client or family member of a client in any place where it can be overheard by others.
- Not contacting any individual or agency outside of Developmental Enhancement, PLC to get personal information about any client or family member of a client
- Not releasing any information, in writing or orally, regarding any client or family member of a client to any person(s) or agencies.
- I understand that violation of these confidentiality principals could potentially result in my termination at Developmental Enhancement, PLC. Further, breaching of confidentiality may subject me to civil or criminal liability.

By my signature below, I indicate that I have read carefully and understand this agreement and that I agree to its terms and conditions.

Parent/Guardian Signature

Date



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Financial Policy and Guarantor Agreement

Please read the Financial Policy and Guarantors Agreement carefully so that you fully understand our financial policy, fees for our services, and your financial responsibility. We would be happy to discuss or answer any questions you may have pertaining to this policy. In order to receive services from Developmental Enhancement, PLC, the Guarantor must guarantee payment to Developmental Enhancement, PLC, for all services provided.

The Guarantor agrees to the following:

1. The Guarantor guarantees that Developmental Enhancement, PLC, will be paid for all amounts owed by the client for services provided by Developmental Enhancement, PLC. All payments are due at the time of service.
2. Developmental Enhancement, PLC is able to bill many insurance companies directly. Clients are responsible for paying the copay and/or deductible at the time of services. The Guarantor remains ultimately responsible for any charges not reimbursed by insurance companies for any reason. Self-paying clients are required to pay the full cost of services at the time services are provided unless a payment plan has been previously approved.
3. Developmental Enhancement, PLC's current fee schedule can be found on the following page. Based on the current fee schedule, amounts expected to be paid by the client for services provided are included, but not limited to, this list. Rates may be subject to change by Developmental Enhancement, PLC at any time.
4. Payment in full is due at the time of service, unless otherwise arranged for ahead of time with your clinician. Developmental Enhancement, PLC, is able to accept cash, check, or credit card for payment.
5. Unless otherwise arranged in advance, any balances owed by the Guarantor not paid within 30 days will receive a billing charge of 1.5%. Guarantor agrees to pay all expenses including, but not limited to, collection agency fees, along with any court costs and actual attorney fees incurred by Developmental Enhancement, PLC in collecting this account.
 - a. The Guarantor will be billed a **\$55 Missed Appointment Fee** for all unexcused sessions that were not canceled or rescheduled within 24 hours of the scheduled time.
 - b. There will be a **\$35 Returned Check Fee** for any checks returned for insufficient funds.
6. The guarantee contained in this agreement is a continuing and unconditional guarantee and may only be withdrawn by the Guarantor by giving written notice to Developmental Enhancement, PLC. All amounts owed prior to Developmental Enhancement, PLC, receiving the withdrawal of guarantee remain the obligation of the guarantor.



DEVELOPMENTAL ENHANCEMENT BEHAVIORAL HEALTH

W// debh.org

1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

7. If the agreement is signed by more than one person, all persons signing the agreement as Guarantor acknowledge that their obligation is joint and several, that revocation of the agreement by one guarantor does not affect the liability of any other Guarantor, and that Developmental Enhancement, PLC, may proceed against each or any one of the persons signing this agreement as guarantor.

8. This agreement is not revoked by the death of a client or Guarantor and will continue in force until all financial obligations owed by the client are fully paid.

9. This agreement shall be construed and enforced according to Michigan law. The Guarantor consents to the jurisdiction of any Michigan court in the event it becomes necessary to institute legal proceedings to enforce the agreement, and waives any objection to personal jurisdiction or venue in such proceedings.

10. The terms of this agreement cannot be changed unless Developmental Enhancement, PLC, consents to the changes in writing.

By signing below, I agree to be the Guarantor and to accept the conditions of this agreement.

Guarantor: _____ Date: _____

Home Address: _____

Home Phone Number: _____ Cell/Work Phone Number: _____

Additional Guarantor: _____ Date: _____

Home Address: _____

Home Phone Number: _____ Cell/Work Phone Number: _____



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Fee Schedule – Developmental Enhancement, PLC’s Charges

Mental Health Assessment and Therapy

90791- Initial Assessment/Therapy, \$195.00
90832- Individual Therapy (30 minutes), \$80.00
90834- Individual Therapy (45 minutes), \$110.00
90837- Individual Therapy (60 minutes), \$155.00
96101- Psychological Testing (per hour), \$120.00

Applied Behavior Analysis (ABA Therapy)

H2019/0364T&0365T- Therapy with Tutor (per 15 minutes), \$18.00
S5108/0368T&0369T- BCBA Supervision (per 15 minutes), \$32.50
H0031/0359T&0360T/0361T- Initial Assessment (per hour), \$145.00
H0032/0359T&0360T/0361T- Re-Assessment, Treatment Plan (per hour), \$135.00
S5111- Family/Parent Training (per 15 minutes), \$25.00

Consultation, Self-Pay Only

15 minutes, \$27.50
30 minutes, \$55.00
45-60 minutes, \$110.00

Additional Charges

Missed Appointment Fee, \$55.00
Returned Check Fee, \$35.00
Telephone Consultation (per 15 minutes), \$30.00
Treatment Summaries/Other Reports (per 15 minutes), \$30.00

Additional services may be offered at mutually agreed upon rates. Services and fees agreed upon for this agreement include the following:

Rates may be subject to change by Developmental Enhancement, PLC, at any time.



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Illness Policy

Please follow these guidelines for when to keep your child home for the safety of your child as well as others. If the condition is contagious and exclusion is recommended, a doctor's note will be required before the child can begin therapy again.

Communicable Disease Chart					
Condition	Incubation Period	Signs and Symptoms	Exclusion from Therapy	Readmission Criteria	Prevention and Treatment
Chickenpox (varicella)	Range 2-3 weeks. Commonly 13-17 days	Fever and rash that may appear first on head, then spread to body. Usually two or three crops of new blisters that heal, sometimes leaving scabs.	Yes	Seven days after onset of rash. Immunocompromised individuals should not return until all blisters have crusted over.	Shingles is a reactivation of the varicella virus. Since contact with the virus may cause chickenpox in a susceptible child, it is recommended that a case of shingles be treated similar to a case of chickenpox
Common Cold	Range 1-5 days. Commonly 2 days	Runny nose, watery eyes, fatigue, coughing, sneezing	No, unless fever	Fever free for 24 hours	Teach importance of washing hands and covering mouth when coughing or sneezing. Colds are caused by viruses, antibiotics are not indicated.
Pink Eye (Conjunctivitis, Bacterial Viral)	Bacterial: 1-3 days. Viral 12 hours - 12 days	Red eyes, usually with some discharge or crusting around eyes	Yes	Return after 24 hours of antibiotic and approval by HCW	Teach importance of washing hands. Allergic conjunctivitis is not contagious and may be confused with bacterial and viral conjunctivitis.
Fever		Oral temperature of 100.4 or greater. Measure when no antipyretics are given	Yes	Fever free for 24 hours	Children should not be given aspirin for symptoms of any viral disease, confirmed or suspected, with consulting a physician.
Head Lice (Pediculosis)	Eggs hatch in 7-10 days	Itching and scratching of scalp. Presence of pinpoint-sized white eggs that will not flick off the hair shaft and live lice	Yes, with live lice	After one medicated shampoo or lotion treatment has been given	Second shampoo or lotion treatment is recommended in 7-10 days. Teach importance of not sharing combs, brushes, hats, and coats. Check household contacts for evidence of infestation
Ringworm	Commonly 4-10 days	Slowly spreading, flat, scaly, ring-shaped lesions on the skin. Margins may be reddish & slightly raised.	No, unless infected area cannot be completely covered	Infected area can be completely covered by clothing or a bandage or treatment has begun	A fungal infection. Treatment is recommended. Keep lesions covered. Teach the importance of not sharing combs, hats, and clothing



DEVELOPMENTAL ENHANCEMENT BEHAVIORAL HEALTH

W// debh.org

1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Influenza	Commonly 1-3 days	Rapid onset of fever, headache, sore throat, dry cough, chills, lack of energy and muscle aches	Yes	After fever subsides	Vaccine available and recommended for children age 6-24 months and those with certain chronic diseases. Anti-viral therapy available for patients with influenza types A and B
Otitis Media (earache)	Variable	Fever, ear pain. May follow respiratory illness	No, unless fever	After sever subsides	Antibiotics are only indicated for acute otitis media
Pertussis (Whooping Cough)	Range 6-21 days. Commonly 7-10 days	Low-grade fever, runny nose, and cough lasting about two weeks, followed by paroxysmal coughing spells and "whoop" on inspiration	Yes	After completion of five days on antibiotic therapy	Vaccine available. Unimmunized contacts should be immunized and receive antibiotic prophylaxis.
Pharyngitis (sore throat)	Variable	Fever, sore throat, often with large, tender lymph nodes in neck	No, unless fever	After fever subsides	
Sinus Infection	Variable	Fever, headache, greenish to yellowish mucus for more than one week	No		Antibiotics are only indicated for long-lasting or severe sinus infections
Streptococcal sore throat and Scarlet fever	Commonly 1-3 days	Fever, sore throat, often with large, tender lymph nodes in neck. Scarlet fever-producing strains of bacteria cause a fine, red rash that appears 1-3 days after onset of sore throat	Yes	24 hours after effective antibiotic treatment has begun and fever subsides	Teach importance of covering mouth when coughing or sneezing. Streptococcal sore throat can only be diagnosed with a laboratory test
Diarrhea	Variable	Stool is watery, and frequency is twice what is usual	Yes, if cause is illness related, or if occurrence/clean-up is continually disrupting therapy	Episode free for 24 hours	
Vomiting	Variable		Yes, if cause is illness related, or is occurrence/clean-up is continually disrupting therapy	Until vomiting resolves (Episode free for 24 hours)	



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Allergy & Medication Form

Client Name _____

Date _____

Please list all the child’s allergies below. For your child’s safety, please be sure to notify Developmental Enhancement of any changes to the allergy list right away. Please also notify Developmental Enhancement with any additional medical information or concerns so we can prepare accordingly.

Allergy To:	Reaction:	Medication/Treatment Reaction:
Medication:	Dosage:	How To Administer:

I agree to give DE’s staff permission to administer the above treatment on my child if necessary.

Parent/Guardian signature

Date



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Consent for Text Message Communication – Applied Behavior Analysis

Developmental Enhancement (DE) is highly committed to ensuring the privacy of our clients' Protected Health Information. All clients receive our Notice of Privacy Practice at the time treatment is initiated.

Many parents have requested that the Board Certified Behavior Analysts (BCBA) and Registered Behavior Technicians (RBT) who are providing services to their child communicate with them using text messaging. Text messaging is not specifically excluded by HIPAA but it is also not recognized as a secure (confidential) method of communication.

I recognize that Applied Behavior Analysis is an intensive treatment with frequent appointments, making communication between parents of clients and the staff providing the treatment difficult. I also recognize that communication between parents and DE staff is important with regard to scheduling issues and getting general updates.

One purpose of HIPAA is to ensure that you as the guardian have control over confidential information. While we are not requesting to communicate with you by text messages (we are able to effectively communicate with secure email with BCBA's or landline telephone), you do have the right to request us to do so if you desire. This would require you to sign this consent giving the treating BCBA and RBT permission to communicate certain information by text message. DE has assessed the risks in this and will take precautions to keep security with text messages as high as possible. However, we cannot guarantee that text messages will be fully secure or confidential.

If you are requesting that the BCBA and RBTs that are treating your child communicate with you by text, DE will have the following conditions and safety measures in place:

1. Mobile phones used by DE staff to send or receive text messages from parents will be password or fingerprint protected. This helps protect confidentiality if a phone is lost or stolen.
2. As parent/guardian, you have the right to send information of your choosing. DE staff will be allowed to send or respond to text messages only pertaining to appointments, schedules, and general updates about daily sessions. DE staff will not be allowed to text photos, videos, or highly confidential information. DE staff will only use first names in text messages.
3. After sending or receiving a text message from a parent/guardian, DE staff will immediately delete the text message. This also helps avoid confidentiality issues if the phone is lost, stolen or viewed by another person.
4. DE staff will not use their personal mobile phones for taking or storing videos or photos of clients.
5. DE staff will only send text messages to parents/guardians. They will only send messages to the phone number(s) you provide on this form. If you change your phone number you will need to sign a new consent. This helps ensure that DE staff will text message to the correct number each time.
6. DE will train our staff on the rules of using text messaging to parents/guardians.
7. You are able to rescind this consent at any time by notifying our HIPAA Security and Privacy Officer, Abbie Westrate, at (616) 604-8492, ext. 231.



DEVELOPMENTAL ENHANCEMENT BEHAVIORAL HEALTH

W// debh.org

1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

I request that the BCBA and RBT that provide services for my child communicate with one or both parents/guardian by text message under the conditions and safety measures outlined above. I fully understand that communicating by text message is not considered a secure manner of communication and understand the risks associated. Despite this, I am voluntarily requesting and giving my consent for communication by text message by DE staff.

Yes No

Parent/Guardian 1: _____

Approved Phone Number: (_____) _____

Parent/Guardian 2: _____

Approved Phone Number: (_____) _____

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

Witness/Date



1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Child Pick Up & Emergency Information

Name: _____ DOB: _____

Relationship: _____ Phone Number: _____

Type of Custody: (Legal Physical Sole Joint Legal Joint Physical None)

Emergency Contact: Yes No Address: _____

Consent to Pick Up: Yes No _____

Consent to Observe: Yes No _____

Name: _____ DOB: _____

Relationship: _____ Phone Number: _____

Type of Custody: (Legal Physical Sole Joint Legal Joint Physical None)

Emergency Contact: Yes No Address: _____

Consent to Pick Up: Yes No _____

Consent to Observe: Yes No _____

Name: _____ DOB: _____

Relationship: _____ Phone Number: _____

Type of Custody: (Legal Physical Sole Joint Legal Joint Physical None)

Emergency Contact: Yes No Address: _____

Consent to Pick Up: Yes No _____

Consent to Observe: Yes No _____

Parent/Guardian Signature

Date



DEVELOPMENTAL ENHANCEMENT BEHAVIORAL HEALTH

W// debh.org

1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

New Referrals- NETWORK 180 ONLY

Client's Name: _____

DOB: _____

Net180 Case ID#: _____

ABA Assessment Date

ADOS Date

Recommended Hours (Per BCBA)

Current/Agreed Upon Hours

Start Date

Level of Services Being Provided

ABI EIBI

Parent/Guardian Signature

Date