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:

☐ 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.
Right to Make a Complaint

As a consumer of Developmental Enhancements health services, you have the right to make a complaint. DE’s protocol for any complaint or concern is as follows; first bring the concern to the BCBA, if they are unable to assist you, or you feel your complaint has not been properly addressed, the BCBA will then contact the Office and Business Managers who will help coordinate a formal meeting with the parents, BCBA, and management. Parents also have the right to request different staff/provider if dissatisfied with services. Developmental Enhancement will then try to accommodate to the best of our ability based on staff schedules and availability. I acknowledge this protocol and agree to communicate any issue/concern to the supervising BCBA and will agree to a formal meeting with management if necessary. I also understand that it is my responsibility to let DE know if I am unsatisfied with any of the staff working with my child.

__________________________ ____________________
Parent/Guardian Signature Date

Responsibility to Attend Scheduled Sessions

As Parent/Guardian of this child, I agree to the following schedule for appointments:

__________________________ from __________am/pm to __________am/pm

We will commit to these times and make a reasonable effort (besides uncontrollable circumstances such as sickness, weather, etc.) to be on time and commit to these responsibilities.

I understand that not attending these committed sessions may decrease or delay the likelihood of my child’s progress.

I also understand that those listed on the Child Pick Up and Emergency Information Form in the Initial Intake Packet are able to pick up my child or sit in on therapy sessions with parent permission. If someone is not listed on the form, the parent/guardian is responsible to call and notify the receptionist to verify who will be picking the child up.

__________________________ ____________________
Parent/Guardian Signature Date

Cancellation/Late Policy

You may be billed a cancellation fee for missed appointments not due to sickness/injury/weather (not applicable for Medicaid clients).

Missed Appointments *(Not due to weather)*:

- Missing 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.
• 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

________________________________________ ____________________
Parent/Guardian Signature Date
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
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 BCBAs 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
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.
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:_____________________
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.
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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incubation Period</th>
<th>Signs and Symptoms</th>
<th>Exclusion from Therapy</th>
<th>Readmission Criteria</th>
<th>Prevention and Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox (varicella)</td>
<td>Range 2-3 weeks. Commonly 13-17 days</td>
<td>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.</td>
<td>Yes</td>
<td>Seven days after onset of rash. Immunocompromised individuals should not return until all blisters have crusted over.</td>
<td>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</td>
</tr>
<tr>
<td>Common Cold</td>
<td>Range 1-5 days. Commonly 2 days</td>
<td>Runny nose, watery eyes, fatigue, coughing, sneezing</td>
<td>No, unless fever</td>
<td>Fever free for 24 hours</td>
<td>Teach importance of washing hands and covering mouth when coughing or sneezing. Colds are caused by viruses, antibiotics are not indicated.</td>
</tr>
<tr>
<td>Pink Eye (Conjunctivitis, Bacterial Viral)</td>
<td>Bacterial: 1-3 days. Viral 12 hours - 12 days</td>
<td>Red eyes, usually with some discharge or crusting around eyes</td>
<td>Yes</td>
<td>Return after 24 hours of antibiotic and approval by HCW</td>
<td>Teach importance of washing hands. Allergic conjunctivitis is not contagious and maybe confused with bacterial and viral conjunctivitis.</td>
</tr>
<tr>
<td>Fever</td>
<td>Oral temperature of 100.4 or greater. Measure when no antipyretics are given</td>
<td>Yes</td>
<td>Fever free for 24 hours</td>
<td>Children should not be given aspirin for symptoms of any viral disease, confirmed or suspected, with consulting a physician.</td>
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<tr>
<td>Head Lice (Pediculosis)</td>
<td>Eggs hatch in 7-10 days</td>
<td>Itching and scratching of scalp. Presence of pinpoint-sized white eggs that will not flick off the hair shaft and live lice</td>
<td>Yes, with live lice</td>
<td>After one medicated shampoo or lotion treatment has been given</td>
<td>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</td>
</tr>
<tr>
<td>Ringworm</td>
<td>Commonly 4-10 days</td>
<td>Slowly spreading, flat, scaly, ring-shaped lesions on the skin. Margins may be reddish &amp; slightly raised.</td>
<td>No, unless infected area cannot be completely covered</td>
<td>Infected area can be completely covered by clothing or a bandage or treatment has begun</td>
<td>A fungal infection. Treatment is recommended. Keep lesions covered. Teach the importance of not sharing combs, hats, and clothing</td>
</tr>
</tbody>
</table>
### 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)
# Allergy & Medication Form

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Date</th>
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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.

<table>
<thead>
<tr>
<th>Allergy To:</th>
<th>Reaction:</th>
<th>Medication/Treatment Reaction:</th>
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<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>How To Administer:</th>
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</table>

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

______________________________
Parent/Guardian signature

______________________________
Date
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 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.
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
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
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