Propel ABA

Intake Form

Name_____ Date of Birth_____

Address_____

Phone Number_____ Email _____

Insurance Co _____ Insurance # _____

Diagnosing Dr _____ Date of Diagnosis _____

Pediatrician _____ Phone # _____

Parents' Names/phone numbers: _____

_____

Siblings Names/Ages _____

Other Family Members in the Home _____

Medical History (Seizures, vision/hearing, recurrent illness, etc.)

Does your child have any allergies or dietary considerations?

Please list any medications, length of time on medication, reason for medication:

How does your child sleep?

Feeding (Feeding/swallowing concerns, food repertoire, favorite foods)

Is your child currently receiving any other services (Speech, Occupational Therapy) and how often?

What school does your child attend?

What grade/type of class are they in?

Has your child received ABA therapy at home or in a center?

Preferred activities?

Communication
How does your child communicate? (Verbally, PECS, AAC device, etc.)

How often does child communicate/When do they communicate most?

Receptive Language?

Play Skills? Parallel or reciprocal play? Functional play with toys?

Relationships with others? (Parents, Siblings, Adults, Peers)

Self-Care
Toileting:

Washing Hands:

Brushing Teeth:

Dressing:

Eating:

Other Self-Help Concerns:

Challenging Behaviors
Does your child display any of the following challenging behaviors…
Aggression:

Bolt:

Flop:

Tantrum:

Environmental Destruction:

Non-Compliance:

Stereotypy:

Other:

What events typically trigger problem behaviors (some examples may be asking them to complete a task, telling them they cannot have a toy or activity, periods of low attention when they need to entertain themselves)?

What do the behaviors typically look like (some examples may be crying, laying on the floor, hitting, kicking, yelling, throwing items, head banging, aggression)

How long to these behaviors typically last?

How many times per week does your child typically engage in problem behaviors?

Does your child engage in any self-injurious behaviors?

Do you ever have to restrain your child?

Community Participation
Behavior in the community?

Community activities they participate in:

Scheduling
Days/times available:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
8-12							
12-3							
3-6							

Propel ABA

Client Email & Texting Informed Consent

Client Name: _____

The purpose of this consent is to review the option of receiving program information and any confidential protected health information (PHI) by email or text. Please review the following and ask any questions related to these two topics before consenting with your signature below.

1. Risk of using email/texting The transmission of program information and/or your PHI by email and/or texting has a number of risks that you should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.

c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

d. Employers and on-line services have a right to inspect emails sent through their company systems and potentially text messages sent through their company issued phone.

e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.

f. Email and texts can be used as evidence in court.

g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Clients/parent's/legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.

b. Email and texts should be brief/concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

c. All email may be printed and filed into the client's medical record. Texts may be printed and filed as well. This makes any information within the text or email a part of the client chart and will be discoverable upon audit, record request, subpoena, and/or court order.

d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts outside of Del Mar Center for Behavioral Health providers without the client's/parent's/legal guardian's written consent, except as authorized by law.

e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.

f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between the Provider and me, and consent to the conditions and instructions outlined above, as well as any other instructions that the Provider may impose to communicate with client by email or text (any specific instructions will be documented within the progress notes of your chart). Based on my understanding of the risks, I consent to the following (check all that apply):

☐ Email communications ☐ Text communications

☐ I do not wish to communicate via email or text

This consent will remain active until the time of discharge from program services or at the time the consent is revoked (whichever is earlier).

Parent/Legal Guardian name _____

Parent/Legal Guardian signature_____ Date_____

Supervisor name _____

Supervisor signature_____ Date_____

Propel ABA

Home Expectations Checklist

Please indicate your awareness of the following expectations by initialing each item

General

_____ Fully functioning smoke alarms

_____ Fully functioning carbon dioxide alarms

____ At least one smoke detector per level in the house

____ At least one fire extinguisher on each floor

____ Working plumbing

____ Working phone service

____ All work areas properly illuminated

____ Adequate, secure parking for when employees are in the home

____ Walkways clear of clutter, debris, and obstructions

____ Absence of rodents / insects

Other Household Members

____ Notification to Del Mar Center for Behavioral Health regarding household members that have medical conditions or may pose medical risk

_____ All household members maintain themselves in a presentable manner during work times (i.e. sober and dressed)

____ Conflicts between family members that may occur during work times are handled respectfully

____ No illegal activities on premises

____ Siblings are not present in the work area unless expressly invited by the employee

____ Employee is not responsible for any damage caused by client in the work area

Bathrooms

____ Regularly cleaned

____ Free of soiled diapers and soiled clothing

____Stocked with supplies (i.e. soap, towels, toilet paper)

Work area

_____ Floor space available

_____ Regularly vacuumed / swept

____ Free of debris

____ Table and chairs available

____ Proper ventilation available

____ Adequate heat / air provided

____ Any work materials are stored securely

Please indicate the following as Yes with a Y or No with a N or Not Applicable with N/A

Firearms

____ Firearms present in the home

____ Firearms locked and properly stored

Animals

____ Animals are in the home

____ Animals are up to date on all recommended vaccines

____ Animals have ever been aggressive

The above conditions are deemed necessary to provide a safe and effective work environment. If conditions are not consistently met, staff has the right to immediately vacate the premises. A team meeting will then be called to discuss conditions.

I, _____, parent / guardian of _____ understand the need to adhere to the above conditions and understand that failure to do so may result in the immediate cancellation of services.

_____ _____

Parent Signature Date

_____ _____

Reviewed by Propel Staff Date

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights
You have the right to:
• Ask to see and get a copy of your health records.
• Have corrections added to your health information.
• Receive a notice that tells you how your health information may be used and shared.
• Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
• Get a report on when and why your health information was shared for certain purposes.
• If you believe your rights are being denied or your health information isn't being protected, you can:
• File a complaint with your provider or health insurer, or
• File a complaint with the U.S. Government.
You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?
• Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
• Health insurance companies, HMOs, most employer group health plans.
• Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?
• Information your doctors, nurses, and other healthcare providers put in your medical record.
• Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
• Information about you in your health insurer's computer system.
• Billing information about you from your clinic/healthcare provider.
• Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)
Providers and health insurers who are required to follow this law must keep your information private by:
• Teaching the people who work for them how your information may and may not be used and shared,
• Taking appropriate and reasonable steps to keep your health information secure.
To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:
• For your treatment and care coordination,
• To pay doctors and hospitals for your healthcare,
• With your family, relatives, friends or others you identify who are involved with

your healthcare or your healthcare bills, unless you object,
• To protect the public's health, such as reporting when the flu is in your area, or
• To make required reports to the police, such as reporting gunshot wounds.
Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:
• Give your information to your employer.
• Use or share your information for marketing or advertising purposes, or
• Share private notes about your mental health counseling sessions.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Propel ABA

Service Agreement

Client Name_____

Parent Participation

Parent/caregiver participation is an expectation of service. Participation may include data collection, and involvement in the implementation of recommended strategies. If there is lack of involvement, Propel ABA reserves the right to reconsider the appropriateness of service.

- If client will be going in to the community during a session, the parent/caregiver is responsible for driving the client.
- If there are expenses associated with any community outings, parents are required to pay for staff.

Parent Cancellation Policy

Consistency of services is critical, however, Propel ABA understands that circumstances, such as illness or family emergency, may arise which require the occasional cancellation of appointments. In the event of a cancellation, please notify the scheduled staff and the case supervisor as soon as possible. Excessive cancellations, more than 25% of sessions in one month, may result in termination of services.

-If child misses school due to illness on the day of session, please notify staff to cancel session.

-If the child or any member of the family has a fever, please notify staff.

-If a session is cancelled by the family, but the staff is not notified, parents will be responsible for the cost of the missed session.

- Flu policy- Please notify staff if any member of your family has the flu prior to them going to the house.

Staff Cancellation Policy

Staff will notify family of cancellations as soon as possible. Sessions cancelled by staff will not be billed. If possible, sessions will be made up during a time agreed upon by the family and staff.

Payment Policy

An invoice will be sent to your home after Propel ABA receives a provider voucher/explanation of benefits from the insurance company. Please pay co payments within one week of receiving the invoice. Please make checks payable to "Propel ABA". If a family has not paid the bill after 30 days, the bill will be sent again. After 60 days the home services will be discontinued until payment is received in full. If a family has difficulty with paying a bill due to financial difficulties, all efforts will be made to create a plan that both Propel ABA and the family can agree to.

Parent and Staff Signature(s)

I have reviewed and agree with Propel ABA's In Home Service Agreement. By signing, I am giving consent for Propel ABA to provide In Home ABA services to my child.

Parent Signature: _____

Parent Signature: _____

Supervisor Signature: _____

Required Paperwork

_____ Current IFSP or IEP

_____ Copy of Insurance Card

_____ Diagnosing Report

_____ Prescription letter for ABA

Propel ABA

Client Overview

Client Name _____ DOB _____

Parent Names _____

Sibling Names _____

Mom Phone Number _____

Dad Phone Number _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number _____

Medical Concerns _____

Allergies _____

Session/Staff Schedule

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday