ABA Care for Kids

Service Policy For _____

In order to insure the best possible outcome for your child, regular participation in wraparound services is required. Please remember that the professional staff that work with your child have set aside certain times and days specifically for your child. The treatment team and you agreed upon these times and days to best meet the needs of your child. We are unable to devote the time and resources of our professional staff to clients and families that do not participate reliably in services.

Appointment- an appointment occurs **ANY** time that **ANY** wraparound staff (BC, MT, BHT, CM or Psychologist) is scheduled to meet with clients/families in any setting, including school, home, community settings or the offices of PA ABA Care for Kids.

Cancellation- if a client cannot attend an appointment, the family is obligated to inform the wraparound staff with whom they are scheduled to meet via telephone. Please call at least 24 hours before the appointment time. In the event of canceling appointments due to doctor's appointments or vacations, please provide us with at least one-week notice, so that your staff may make other arrangements. Exceptions can be made in cases of emergencies or sudden illness. In those instances, a telephone call is required as soon as possible before the time of the appointment. Appointments that are postponed without sufficient notice are considered missed appointments since the professional staff has reserved the initial time for your child. Appointments in which an adult caregiver is not present when therapeutic staff are scheduled to work with client are considered missed appointments since professional staff are unable to provide services without adult caregiver participation and attendance.

Missed Appointment- a missed appointment occurs when a client/family does not attend an appointment with a wraparound staff without calling to cancel, or calling with too little notice. If a client/family does not attend within **fifteen minutes** of the appointment time the appointment is considered missed.

Multiple Missed/Canceled Appointments

Multiple cancellations and missed appointments impact on your child's progress. They also take up the time of the professional staff that could be used more effectively.

Services may be discontinued if a client cancels or misses 25% or more of the scheduled appointments in a month.

It is important that our staff be able to maintain consistent communication with you in regards to your child's services (scheduling appointments, treatment plan reviews, consultation, and case management).

Services may also be discontinued if staff have made 2 or more separate attempts to contact you without any response.

If your child is discharged from services you will receive a letter providing you the date your child was discharge and why. Your child will be referred back to Magellan (this may take place without your request) and/or services can be transferred to another provider company when requested.

Psychological Evaluations- we need to schedule psychological evaluations four to six weeks in advance. If you do not attend an appointment for a psychological evaluation, we cannot guarantee that another appointment will be available before the authorization of your child's services expires. As a result, you risk a lapse in services and the reassignment of your child's staff. As with all appointments, please call 24 hours in advance if you must cancel an appointment with the psychologist. Direct all phone calls regarding psychological evaluations to the main office **(267)897-4136.**

Psychological evaluations /written orders from psychologist can be completed through telehealth during Covid19 pandemic and will resume to office appointments.

My signature indicates that I have read and understand the ABA Care for Kids Service Policy.

_____ _____

Signature Date

_____

Relationship

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Welcome Packet Confirmation

I, the parent/guardian of _____, have received the ABA Care for Kids Welcome Packet. This packet includes various information that we hope will be helpful to you. In addition, we request that you fill out some forms (in the front sleeve) that are necessary and useful for us. If unsure, it is appropriate for the behavior specialist, mobile therapist or case manager to help you complete these forms. These forms are maintained in your child's file and the information is kept confidential.

Parent/Guardian _____ Date _____

Witness _____ Date _____

ABA Care for Kids

630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Consents to IBHS from ABA Care for Kids

I _____ the parent of _____ agree

to receiving services from ABA Care for Kids.

_____(birthday)

I understand that while receiving services the following information will be needed for the purpose of **reauthorization and continuity of care.**

The information release is as follows:

__x___Plan of Care	__x___Service Plan	__x___Behavioral Program
__x___ ITP	_ x____Psychiatric evaluation	__x___Psychological Evaluation
__x___Medical history/medications	__x____Individual Education Plan	__x____ Academic evaluation
__x___Biopsychosocial History	__x____Discharge Summary	__x___Discharge/Aftercare Plan
__x___Diagnostic History	__x____Developmental History	
_____Other_____		

Please forward the information to the attention of ABA Care for Kids _____

Name of Facility, Agency, Person

630 Freedom Business Ctr Dr. King of Prussia Pa 19406 3rd FL. Ste 69 267-897-4136

_____

Address Phone number

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and this permission is limited for the sole purposes listed above. I understand this will be effective one year after the date of my signature unless I choose to terminate agreement prior to one year.
*To terminate agreement contact director, who will then complete discharge summary and services promptly.

This consent shall be effective from _____ until _____.

For one year

Parent/Guardian_____ Date _____

Youth (over age 14) _____ Date_____

Witness _____ Date_____

ABA Care for Kids

630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Consent For Release of Information

I hereby authorize **ABA Care for Kids** to release/receive information from the records of

_____.

_____(birthday) for the purpose of **re-authorization and continuity of care.**

The information release is as follows:

__x__Plan of Care	__x___Service Plan	__x___Behavioral Program
__x__ ITP	_____Psychiatric evaluation	__x___Psychological Evaluation
_____Medical history/medications	_____Individual Education Plan	_____ Academic evaluation
_____Biopsychosocial History	___x___Discharge Summary	__x___Discharge/Aftercare Plan
_____Diagnostic History	_____Developmental History	

__x___Other (specify) Correspondence, cover letter, addendums

Please forward the information to the attention of Community Care Behavioral

Name of Facility, Agency, Person

1400 N. Providence Rd. Suite 310 Media, PA 19063 1-800-251-2224

Address Phone number

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and this permission is limited for the sole purposes listed above. I understand this will be effective one year after the date of my signature unless I choose to terminate agreement prior to one year.
*To terminate agreement contact director, who will then complete discharge summary and services promptly.

This consent shall be effective from _____ until _____.

For one year

Parent/Guardian_____ Date _____

Youth (over age 14) _____ Date_____

Witness _____ Date_____

ABA Care for Kids

630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Consent For Release of Information: School

I hereby authorize **ABA Care for Kids** to release/receive information from the records of

_____.

_____(birthday) for the purpose of **continuity and efficacy of behavioral care.**

The information release is as follows:

_____Plan of Care	_____Service Plan	_____Behavioral Program
_x____ ITP	__x____Psychiatric evaluation	__x___Psychological Evaluation
_x____Medical history/medications	_____Individual Education Plan	_____ Academic evaluation
_____Biopsychosocial History	_____Discharge Summary	_____Discharge/Aftercare Plan
_x____Diagnostic History	__x____Developmental History	
_____Other_____		

HIV-related information contained in the parts of the record indicated above will not be released through this consent. A separate consent is required in order to release HIV-related information.

Please forward the information to the attention of

_____

Full Name of School Staff Contact Person (please include title) and phone number

_____

School Name and Address School District Current Grade

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and this permission is limited for the sole purposes listed above. I understand this will be effective one year after the date of my signature unless I choose to terminate agreement prior to one year.
*To terminate agreement contact director, who will then complete discharge summary and services promptly.

This consent shall be effective from _____ until _____.
For one year

Parent/Guardian_____ Date _____

Youth (over age 14) _____ Date_____

Witness _____ Date_____

I decline to allow communication with IBHS provider and school.

Parent/Guardian _____ Date_____

ABA Care for Kids

630 Freedom Business Center

King of Prussia, PA 19406
267-897-4136

Consent For Release of Information:

I hereby authorize **ABA Care for Kids** to release/receive information from the records of

_____.

_____(birthday) for the purpose of **continuity and efficacy of behavioral care.**

The information release is as follows:

__x___Plan of Care	_____Service Plan	_____Behavioral Program
__x___ ITP	_____Psychiatric evaluation	__x___Psychological Evaluation
_____Medical history/medications	_____Individual Education Plan	_____ Academic evaluation
_____Biopsychosocial History	___x___Discharge Summary	__x___Discharge/Aftercare Plan
_____Diagnostic History	_____Developmental History	

_x____Other (specify) verbal and written correspondence with professionals outside of ABA Care for Kids

Please forward the information to the attention of _____

Name of person or organization

_____

Address Phone number

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and this permission is limited for the sole purposes listed above. I understand this will be effective one year after the date of my signature unless I choose to terminate agreement prior to one year.
*To terminate agreement contact director, who will then complete discharge summary and services promptly.

This consent shall be effective from _____ until _____.
For one year

Parent/Guardian_____ Date _____

Youth (over age 14) _____ Date_____

Witness _____ Date_____

I decline to allow communication with person or organization

Parent/Guardian _____ Date_____

ABA Care for Kids

630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Consent For Release of Information: parent/legal guardian
Youth 14 years of age or older

(This consent may be removed if under 14 years of age)

I hereby authorize **ABA Care for Kids** to release/receive information from the records of

_____.

_____(birthday) for the purpose of **reauthorization and continuity of care.**

The information release is as follows:

__x____Plan of Care	___x__Service Plan	__x___Behavioral Program
__x___ ITP	___x___Psychiatric evaluation	__x___Psychological Evaluation
__x__Medical history/medications	___x___Individual Education Plan	__x___ Academic evaluation
__x___Biopsychosocial History	___x___Discharge Summary	__x___Discharge/Aftercare Plan
__x___Diagnostic History	___x___Developmental History	

__x___Other (specify) verbal and written correspondence with professionals outside of ABA Care for Kids

HIV-related information contained in the parts of the record indicated above will not be released through this consent. A separate consent is required in order to release HIV-related information.

Please forward the information to the attention of _____

Name of Parent or Legal Guardian

_____

Address Phone number

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and this permission is limited for the sole purposes listed above. I understand this will be effective one year after the date of my signature unless I choose to terminate agreement prior to one year.
*To terminate agreement contact director, who will then complete discharge summary and services promptly.

This consent shall be effective from _____ until _____.

For one year

Parent/Guardian_____ Date _____

Witness _____ Date_____

ABA Care for Kids

630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Consent For Release of Information: Primary Care/Psychiatrist

I hereby authorize **ABA Care for Kids** to release/receive information from the records of

_____.

_____(birthday) for the purpose of **continuity and efficacy of behavioral care**

The information release is as follows:

_____Plan of Care	_____Service Plan	_____Behavioral Program
_x____ ITP	__x____Psychiatric evaluation	__x___Psychological Evaluation
_x____Medical history/medications	_____Individual Education Plan	_____ Academic evaluation
_____Biopsychosocial History	_____Discharge Summary	_____Discharge/Aftercare Plan
_x____Diagnostic History	__x____Developmental History	

_x____Other_____

HIV-related information contained in the parts of the record indicated above will not be released through this consent. A separate consent is required in order to release HIV-related information.

_____

Full Name of Primary Care Physician/Psychiatrist

_____

Facility Name and Address

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and this permission is limited for the sole purposes listed above. I understand this will be effective one year after the date of my signature unless I choose to terminate agreement prior to one year.
*To terminate agreement contact director, who will then complete discharge summary and services promptly.

This consent shall be effective from _____ until _____.
For one year

Parent/Guardian_____ Date _____

Youth (over age 14) _____ Date_____

Witness _____ Date_____

I decline to allow communication with IBHS provider and school.

Parent/Guardian _____ Date_____

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Does your child currently receive services from another provider?

____YES ____NO

Do ABA Care for Kids need to request your son/daughter's information from any additional provider?

___YES ___NO

If yes, list the name(s) of the providers and complete additional release of information form.

1) _____

2) _____

3) _____

Guardian _____ Date _____

Client Signature (if over 14) _____ Date _____

Witness _____ Date _____

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

CONSENT FOR SWIMMING

This consent is for clients receiving BHT services only. If you do not receive BHT services, you may remove this consent from the packet.

I, _____, agree and consent to having a BHT accompany my child,

_____, to the camp pool or to the community pool. I understand that a lifeguard from that pool needs to be present at all times. I also understand that if attending a community pool, the parent or guardian needs to be present as well. These consents expire one year from the date signed.

I understand consent will be effective for one year after the date of my signature, unless otherwise specified.

Parent/Guardian _____ Date _____

Child (if over 14) _____ Date _____

Witness _____ Date _____

I decline to sign _____ Date _____

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Early Periodic Screening Diagnosis and Treatment (EPSDT)
(For members under the age of 18 only)

Primary Care Provider: _____

Address: _____

_____

Date of Last Physical: _____

☐ I have been made aware that my child is eligible for an annual physical health exam through Medical Assistance.

Parent/Guardian _____ Date _____

Witness _____ Date _____

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

HIPAA CONSENT

The "Notice of Privacy Practices" provides information about how ABA Care for Kids may use and disclose protected health information about my child. I understand that I have the right to review the notice before signing this consent. I understand that ABA Care for Kids may sometimes disclose information about me without my consent as required or permitted by law. If ABA Care for Kids changes the Notice, I will be sent the revised form.

I have the right to request that ABA Care for Kids restricts how protected health information about my child is used or disclosed for treatment, payment or healthcare operations. ABA Care for Kids is not required to agree to this restriction, but if agreed, ABA Care for Kids is bound by that agreement.

I understand that by submitting a written request, I may receive a copy of my child's file, request an amendment to the file; request alternative communication methods; request limited distribution of information in the file, or obtain an accounting of disclosures. I understand that I will receive assistance as necessary to submit a written request.

I understand that I can contact ABA Care for Kids at **267-897-4136**

By signing this form, I consent to the use and disclosure of protected health information about my child only for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where ABA Care for Kids has already made disclosures based upon our prior consent. If I need assistance to make the request in writing it will be provided to me.

Guardian _____ Date _____

Client Signature (if over 14) _____ Date _____

Witness _____ Date _____

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Procedure Regarding Mandated Reporters

ABA Care for Kids is committed to providing for the health, safety and welfare of all children in our services.
ABA Care for Kids staff are mandated reporters. In the event that a child shares information regarding abuse or neglect, or staff are witness to an incident, ABA Care for Kids staff are required by the State of Pennsylvania to divulge this information to Social Services for Children & Youth.

I, _____, the parent/legal guardian of
(parent/legal guardian)

_____, have been informed of the procedure regarding
(Client)

mandated reporters.

Parent/Guardian _____ Date _____

Witness _____ Date _____

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

CONFIDENTIAL PROFESSIONAL PEER REVIEW CONSENT

I, _____, give permission for ABA Care for Kids to review pertinent case information with professional peers for the Purpose of case consultation. I am aware that this peer review process is confidential and will only be reviewed by professional/clinical members of ABA Care for Kids.

_____ _____
Signature Date

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

CONSENT FOR PSYCHOLOGICAL EVALUATION/WRITTEN ORDER

I, _____, agree and consent to the scheduled psychological evaluation of
(parent/legal guardian)

_____.

(Client)

I understand this consent will be effective for one year after the date of my signature, unless otherwise specified. I also understand that if I decline to sign, it is my responsibility to locate a private psychologist/psychiatrist/developmental pediatrician for periodic review of my child for the purposes of continuing authorization.

Parent/Guardian _____ Date _____

Child (if over 14) _____ Date _____

Witness _____ Date _____

I decline to sign _____ Date _____

Please note that by declining to sign this consent, ABA Care for Kids will be unable to make any future recommendations for services for your child.

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

AUTHORIZATION TO UTILIZE TECHNOLOGICAL DEVICES

I, _____, hereby authorize ABA Care for Kids to use technological devises to properly document a meeting/session or to assist in the development of therapeutic interventions, curriculum, and/or programs that will assist my child, or for assisting with educational and training purposes within ABA Care for Kids. Anything used to record my child's name or image will be kept confidential as governed by the policies of ABA Care for Kids. **Please check the boxes indicating the devices you authorize ABA Care for Kids:**

☐ Audio Tape

☐ Video Tape

☐ Camera (video/Pictures)

Other: _____

I understand this authorization will be effective immediately, and is effective for the date of my signature only unless specified here: time period _____ to _____

Parent/Guardian _____ Date _____

Child (if over 14) _____ Date _____

Witness _____ Date _____

I decline to sign _____ Date _____

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Consent for Shadowing/On-Site Supervision

I, _____, agree and consent to the shadowing and on-site Supervision of

my child, _____, while the current BHT/BC is providing behavioral health services at home, at school, and in the community (*please circle all that apply*). Shadowing consists of a BHT or BC in-training accompanying the BHT/BC during a session which is required by our licensing bodies and can be a beneficial process for those learning to work with children with special needs. On-Site Supervision, also a requisite of licensing organizations, involves the Supervisory staff (consisting of Clinical Supervisor or Program Director) providing clinical feedback, on location, to the current BHT for the purposes of maintaining effective oversight of services provided.

I understand this consent will be effective for one year after the date of my signature, unless otherwise specified.

Parent/Guardian _____ Date _____

Child (if over 14) _____ Date _____

Witness _____ Date _____

I decline to sign _____ Date _____

ABA Care for Kids
Insurance Information Form

Child's Name _____

Date of birth_____SS#_____Medical Assistance renewal date_____

Parent/Guardian Name _____

Address_____Telephone_____

Please check the box that applies:

☐ My child DOES NOT currently have coverage under private health insurance.

☐ My child Does currently have coverage under private health insurance.

Please sign the remainder of this form and return to ABA Care for kids.

Private health insurance information

Insurance Company Name_____

Insurance Company Address_____

Insurance Company Phone Number_____

Subscribers Name_____Date of birth_____SS#_____

Insurance ID#_____Group #_____Insurance renewal date_____
Is your insurance plan self -insured? Yes_____No_____
Does your employer have more than 50 Employees in the company yes_____No_____

_____ _____
Signature Date

By signing this form, I allow ABA Cares for kids to release the following information to the above insurance company.

___Plan of care	___Service Plan	___Behavioral Program
___Treatment plan	___Psychiatric Evaluations	___Psychological Eval
___Medical History/Medications	___Individualized Education Plan	___Academic Eval
___Biopsychosocial History	___Discharge Summary	___Discharge/ aftercare plan
___Diagnostic Summary	___Developmental History	___Other (Progress of treat

ABA Care for Kids
Intensive Behavior Health Services
Emergency Contact/Parental consent form

Child's name		Social security	Birthdate
Gender	Ethnicity	Religion	Primary Language
Home address			
Mother Name/Legal Guardian		Home Telephone #	
Business Name		Business Telephone #	
Business address			
Father Name/Legal Guardian		Telephone #	
Home address if different than mother			
Business Name	Business Address		Business telephone #
Emergency Contact		Telephone #	
Address			
Person to whom the child can be released		Address/Telephone # when child is in care	
Name of Child's Physician		Address/Telephone #	
Special disabilities if any		Allergies including medication reactions	
Medical or Dietary information necessary in an emergency situation			
Medication/Special Conditions			
Additional information on special needs of child			
Health Insurance Coverage for child or Medical Assistance Benefits			
Policy #			

Signature Date

ABA Care for Kids
630 Freedom Business Center
King of Prussia, PA 19406
267-897-4136

Telehealth Services

Services provided via zoom or phone

____ I give my consent to telehealth services from ABA Care for Kids (Behavioral Consultant, Mobile Therapy, Behavioral Health Technician)

____ I DO NOT give my consent to telehealth services from ABA Care for Kids (Behavioral Consultant, Mobile Therapy, Behavioral Health Technician)

Parent/Guardian _____ Date _____

Child (if over 14) _____ Date _____

Witness _____ Date _____

I decline to sign _____ Date _____