



Dear Parent(s),

Thank you for your interest in our program. We appreciate you selecting Sunderlin Behavioral Intervention as your child's Applied Behavior Analysis (ABA) provider. We will assist you with verifying your insurance benefits for autism coverage. If ABA is a covered benefit under your insurance plan, we will obtain an authorization from your insurance to start services. In order to begin the process, we need the documents outlined below.

Attached you will find the following documents:

- Private insurance information form
- Confidentiality policy and client release of information
- Release of media form
- Notice of privacy practices
- Consent and agreement for behavioral assessment
- Financial policy patient responsibility
- Intake form
- Sick child policy and company closures forms
- Credit card form
- ABA history questionnaire

In addition, the following documents are **REQUIRED** to verify ABA benefits and to submit a request for authorization to your insurance company. If you have not previously provided these please provide:

- A copy of the front AND back of your child's insurance card. Please include secondary insurance card, if any.
- A prescription or letter from a medical doctor or a licensed professional stating that your child has a diagnosis of autism spectrum disorder (ASD).

Please complete, sign and return **all** documents to our office as soon as possible. This information may be faxed, mailed, or emailed to us:

3113 W Rose Hill Street
Boise, ID 83705
Phone: (805) 230-2710
Fax: (805) 823-4462

intake@sunderlinbcba.com

Upon receipt of these documents, our office will verify your insurance plan and notify you of your autism benefits. If you have any questions, please contact our Office Manager at (805) 230-2710

Sincerely,

Yrenka Lolli-Sunderlin MS, BCBA
Executive Director

Enclosures



CONFIDENTIALITY POLICY AND CLIENT RELEASE OF INFORMATION

At Sunderlin Behavioral Intervention all client’s records (verbal or written) will not to be released or shared with outside parties unless a consent form has been signed. In such case, the information may only be shared with the specific parties authorized on the consent form.

I hereby give my permission for all information concerning the evaluation and treatment of my child to be released and transmitted between the Company and the following professionals or agencies:

Agency: _____

Child’s Pediatrician: _____

Address: _____

Phone #: _____ Fax #: _____

Other: _____

Child’s School: _____

Address: _____

Phone #: _____ Fax #: _____

Other: _____

I understand that this release form is valid for the period of time in which the above-named client is in active treatment with Sunderlin Behavioral Interventions. All or any of this release is cancelled upon written notification from the undersigned. A photocopy of the consent for release of information is as valid as the original.

I give permission for my child to be in the therapy room. I understand that other parents may be present and watching their own children at the same time.

Initial: _____ Yes No Date _____

I give permission for my child to participate in a group setting which may be observed by other parents observing their child at the same time.

Initial: _____ Yes No Date _____

The caregiver/parent(s) acknowledges that they have been informed and understand our confidentiality policy.

Print Client’s Full Name: _____

Print Legal Guardian’s Full Name: _____

Signature of Legal Guardian: _____ **Date:** _____



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Corporate Office: Phone (208) 297-1405 Address 3113 W Rose Hill St. Boise, ID 83705

Who Will Follow This Notice?

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

Your Health Information

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use and Disclose Health Information About You

For Treatment

We may use health information about you to provide you services. We may disclose information about you to treatment staff, office staff or other personnel who are involved in taking care of you and your services

For example, your occupational therapist may be treating your child for a developmental condition and may need to know you child has other developmental challenges pertaining speech. The therapist may discuss your child's case with the speech therapist to determine the most appropriate care for your child.

Personnel in our office may not share information with people who do not work in our office without written authorization from you.



For Payment

We may use and disclose health information about you so that the services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Service Operations

We may use and disclose health information about you in order to run the office and make sure that you and our clients receive quality care. For example, we may use your information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Scheduling and Other Routine Office Operations

We may use your information to contact you regarding scheduling. We may use your information to contact you for other routine office operations such as completing required paperwork.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Public Health Risks

We may disclose health information about you for public health reasons to prevent or control disease, injury or disability, suspected abuse or neglect, and/or non-accidental physical injuries.



Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your relative when you bring your relative with you into the treatment room during treatment or while treatment is discussed.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:



Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to a Clinical Director in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- A. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- B. Is not part of the health information that we keep.
- C. You would not be permitted to inspect and copy.
- D. Is accurate and complete.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about additional treatments not being provided by this office.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit a Request for Restricting Uses and Disclosures and Confidential Communications Form Information to a Clinical Director.

Right to Request Confidential Communications

You have the right to request that we communicate with you about service matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, please do so in writing to a Clinical Director. We will not ask you the



reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact a Clinical Director.

Changes to This Notice

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. Please submit your complaint to 3113 W. Rose Hill Street, Boise ID 83705. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Sunderlin Behavioral Interventions.

Client's Full Name: _____

Legal Guardian's Full Name: _____

Legal Guardian's Signature: _____ **Date:** _____



Consent and Agreement for Behavioral Assessment

I, _____, agree to allow the individual named below to participate in the following services:

- Behavioral Assessment
- Report Writing

This agreement concerns:

Client's Full Name: _____ DOB of Patient: _____

I understand that these services may include direct, face-to-face contact, interviewing, behavioral, social, and communication skills assessment. They may also include time required by a BCBA (Board Certified Behavior Analyst) for the reading of records, consultations with other Clinicians and Professionals, compiling and evaluation assessment results, and any other activities to support these services.

I understand this evaluation is to be done for the purpose(s) of:

1. Making recommendations for behavioral, educational, social, and communication skills treatment planning.

I also understand Sunderlin Behavioral Interventions agree to the following:

1. The procedures for selecting and conducting assessments, interpreting and storing the results, and maintaining my privacy will be carried out in accord with the widely accepted rules and guidelines or organizations (e.g., HIPAA, FERPA, etc.)
2. Assessment methods will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and populations have been established.) All assessment are chosen and conducted, and the results are evaluated based on findings and guidelines from the scientific and professional literature.
3. Reports and assessment results will be kept in a safe place. We agree to help as much as we can, by supplying full answers, making an honest effort, and working as best we can to make sure the findings are accurate

Signature of Legal Guardian: _____

Date: _____



FINANCIAL POLICY & PATIENT RESPONSIBILITY

It is the Patient’s Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co- payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physicians (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment and or deductible at the time of the service.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- Outstanding payments past 30 days will accrue a \$50 late fee
- To notify our office immediately when your insurance plan or carrier has changed.

It is Sunderlin Behavioral Interventions responsibility:

- To provide quality therapy services
- To verify benefits and eligibility as a courtesy to the patient (please refer to the first bullet point)
- To file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

Cancellation Policy:

Appointments cancelled with less than **18-hour notice** are charged a **\$40 cancellation fee** No

Show Policy:

If an appointment was scheduled **AND** not cancelled, in that instance, a **“no show” fee of \$60.00 will be assessed.**

Credit Card Policy:

A Credit card form **must** be provided before the first initial session date. Credit card payments are processed on a weekly basis for services rendered the prior week.

Preferred Email Address for Billing Receipts: _____

Financial Policy Acknowledgement:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage. I am ultimately responsible for the balance on my account for any services rendered.

Legal Guardian’s Signature: _____ **Date:** _____

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claims for me by Sunderlin Behavioral Interventions. I also authorize my insurance carrier(s) to make payment directly to Sunderlin Behavioral Intervention.

Legal Guardian’s Signature: _____ **Date:** _____



Sick Child Policy

The following policy was developed to protect the health of your child and family, the health of other children using Sunderlin Behavioral interventions Autism Services and our service providers. Because our staff may serve multiple children over the course of a day, it is important for families using our services to understand the importance of protecting our staff from exposure to infectious diseases or illness. Not only does this protect our staff from developing illness, but it also protects all children and families using our services (some of whom may have diminished abilities to fight infection.)

Policy:

A parent must cancel a session whenever their child exhibits any one of the following symptoms within the last 24 hours:

- A temperature of **100° or higher**
- Diarrhea (2 occurrences)
- Vomiting (1 Occurrence)
- Any rash other than diaper rash
- Eye infection
- Bad cold with hacking or persistent cough, productive cough with green or yellow phlegm being coughed up.
- Nasal discharge that is either green or yellow
- Extreme irritability or exhaustion
- Children must be **fever-free for 24 hours** without the use of Tylenol (or other similar medication) before returning to therapy.

If anyone else in the family is experiencing any of these symptoms, they should be kept away from the providers who come into your home. If anyone in the family is experiencing a highly contagious disease, such as **pink eye, strep, head lice, impetigo, covid 19, or hand-foot-mouth disease** sessions should be canceled.

We realize that intervention sessions are very important to your child, however, providing intervention sessions to a child who is not feeling well is not therapeutic. Autism services staff will use their discretion in deciding whether therapy should continue when a child is ill. Likewise, our staff will cancel a session if they feel that they had the potential to expose your child to illness.

Thank you for respecting the well-being of our staff and other children and families using our services.

By signing below, I acknowledge that I have read and understand the sick policy outlined above. I commit to following these standards to protect the health and well-being of the service providers as well as other children served by Sunderlin Behavioral Interventions.

Parent/Guardian Signature: _____

Date: _____



Intake Form for Clients

Client Information

Name Last:

First:

Middle:

Street Address:

Apartment #:

City:

State:

Zip:

Sex:

Diagnosis

Date of Birth:

Primary Guardian Information

Name Last:

First:

Middle:

Street Address:

Apartment #:

City:

State:

Zip:

Email:

Primary Phone #:

Date of Birth:

Relationship to client:

Social Security #:

Insurance Information

Primary Insurance Company:

Phone #:

Policy ID #:

Group #:

Secondary Insurance Company:

Phone #:

Policy ID #:

Group #



Services

Services Interested in (check all that apply):

- Adult Life Coach Social Skills Group Parent Training Applied Behavioral Analysis

If interested in school services, please answer the following:

School Name: _____ **School District** _____ **Name of Teacher/Director** _____

Street Address: _____ **Phone #:** _____

City: _____ **State:** _____ **Zip:** _____

Behavioral Concerns:

Pediatrician Information:

Name: _____ **Phone #:** _____ **Fax #:** _____

How did you hear about us? (Check all that apply)

- ALP Website Facebook Community Event

- Doctor/Friend: _____ Other: _____



We normally operate service between the hours of 8am and 8:30pm Monday-Friday and variable hours on Saturday and Sunday. Please indicate the full days and times your child is available to receive services in the chart below. The more availability you provide, the better we are able to plan for your child and schedule services.

*Please note, any changes to your original schedule agreement must be reviewed with your Supervisor and submitted in writing two weeks prior to the requested change if a vacation is two or more weeks, we cannot guarantee the same therapist/may result in being placed on the waitlist upon return.

Client’s Full Name: _____

Legal Guardian’s Full Name: _____

Days	Availability for Session at Home
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

If interested in services at school, please write in the times your child has school each day in the chart below:

Days	Availability for Session at School
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	



Medical History

Are Immunizations up to date? Yes No

Medication Allergies: _____

List of current Medications:

Medication	Dose	Reason

Patient History:

<input type="checkbox"/> Ear infections	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Muscle Disorder
<input type="checkbox"/> Headaches	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Endocrine Disorder	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Seizures

Applied Behavioral Applied Questionnaire

Has your child received prior ABA Services? Yes No

If so, please provide licensed provider information:

Name: _____ NPI: _____ Phone #: _____

Address: _____

Are there any family or legal issues (Divorce, Child Custody, ETC.)?

If so briefly describe:

Are there any Spiritual/Cultural beliefs that would interfere with receiving ABA Treatment?

If so, please explain.:



Family History

(Please check any of the following conditions that are or have been present in the clients immediate or extended biological family)

	Siblings	Mother	Father	Mothers Relative	Fathers Relative
Developmental Delay					
ADHD					
Intellectual Disability					
Special Education					
Cerebral Palsy					
Blindness					
Deafness					
Seizures					
Autism					
Tics/Tourette's					
Enuresis (bedwetting)					
Depression					
Anxiety					
Suicide					
OCD					
Schizophrenia					
Sleep Disorder					
Alcoholism					
Drug Abuse					
Other					



The WorkEnvironment

Sunderlin Behavioral Interventions is under legal obligation to provide a safe and harassment free working environment for all our staff. This includes the environments where we provide services to your family member such as your home. Please ensure that your home is free of any hazards prior to our session and that you interact with all staff members in a professional manner.

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

General

- _____ Fully functioning smoke alarms
- _____ Fully functioning carbon dioxide alarms
- _____ Working plumbing
- _____ Working internet service
- _____ All chemicals cleaning products need to be properly stored
- _____ All sharp objects need to be properly secured and stored

Other Household Members

- _____ 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 and are handled respectfully
- _____ No illegal activities on premises
- _____ Siblings are welcome to participate unless recommended not to by the clinical team
- _____ 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
- _____ Tables and chairs available
- _____ Any work materials are stored securely



The WorkEnvironment (continued)

Please indicate the following as Yes or No or 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, the staff has the right to immediately vacate the premises. A team meeting will then be called to discuss the 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/Guardian Signature: _____

Date: _____



Parent/Caregiver/Sibling Involvement

Applied Behavior Analysis

During therapy sessions, we require parent/caregiver participation. You are welcomed to watch sessions, ask questions, and participate directly. When you participate directly, our Behavioral Therapists are trained to step back so that you become your family member's communication partner. Case Supervisors can provide direct Parent Training, coaching, and offer tips on incorporating program goals into your daily activities and routines. Please note that if you choose to step in during an unwanted behavior, the Behavioral therapist will still follow guidelines to avoid escalating the situation. However, the Behavioral Therapists are trained to provide positive supports for unwanted behaviors, and it is not necessary that you step in. If the Behavioral Therapists needs your assistance, they will directly request that you step in. If a behavior escalates to an emergency situation and may have the potential for great bodily injury, we will request assistance form law enforcement or other emergency responders.

Many of our goals are written with generalization criteria which require participants to be able to demonstrate skills with parents or caregivers. We do this because research has shown that parent involvement facilitates generalization of skills and results in the best outcomes for participants. Additionally, this practice meets the compliance of the funding sources for parent education and training. To demonstrate generalization, it is typically recommended that a parent or caregiver actively participate in the sessions.

Siblings may be requested to participate in a part of the session. When a sibling participates, it is generally best that specific goals are identified for these groups' times, that participation is time limited, and that a parent or other caregiver participates and maintains supervision of the sibling.

Make up Sessions

Every effort will be made to make up sessions cancelled by Sunderlin. Please note that if you abruptly change your schedule for any reason, for more than two consecutive weeks, we are unable to guarantee that your session times and Behavioral Therapists will remain the same upon your return.

We make every effort to make up all cancellations. We do not make up sessions that fall on Sunderlin's Company Holidays (A Holiday Schedule is included).

Make up sessions may be conducted by any of your family members current Behavioral Therapists, a designated substitute who is familiar with your family's case, or occasionally by your family member's Clinical Supervisor.

Questions or Concerns

Sunderlin is committed to providing quality services to all clients. If the clients are dissatisfied with any service or personnel, they are encouraged to communicate their concerns to the Clinical Supervisors. We pride ourselves on working together with our families and teams encourage open conversation about concerns. When conflicts or concerns arise with your team, we recommend the following procedures. Please contact your Case Supervisor to discuss your concerns. Do not bring concerns to your Behavioral Therapists. You are also welcome and encouraged to contact the case manager from your insurance funding source with your concerns. Further information is available in our grievance policy.

Again, we are very happy to be working with you and your family member. We look forward to an ongoing collaborative environment.



Parent/Guardian Participation Policy

Please initial below on each line after reading the summarization of important policies regarding our service delivery agreement.

- _____ You or your authorized representative (e.g., grandparent, other relative, and daycare provider) must be present and participate during the session to maximize the impact of the intervention. (Must be 18 years and older)
- _____ You are encouraged to ask questions, actively participate in your family member’s session and incorporate the activities and techniques you learn into your family’s daily routine.
- _____ Since regular sessions are required for your family member to make progress, you are asked to minimize cancellation of your family member’s sessions.
- _____ Please notify the Behavioral Therapist/Case Supervisor 18 hours in advance if you must cancel a Session. Three (3) “no shows” without prior notice will result in notification to your Insurance Funding Source and possible Discharge of Service from Sunderlin.
- _____ Observation and Treatment overlaps (ABA services) are an essential part of Supervision and Teaching. Each family is expected to allow observations and shadow appointments in their home.
- _____ At least one Caregiver is expected to participate regularly scheduled Supervision meetings where progress toward goals will be reviewed.
- _____ Parent must stay within close proximity while session is in progress to supervise and intervene when necessary. Should a parent leave the room for any reason the session will be suspended until the parent returns.

I have read and acknowledge the Participation Policy.

Parent/Guardian Signature: _____

Date: _____



Caregivers' Code of Conduct

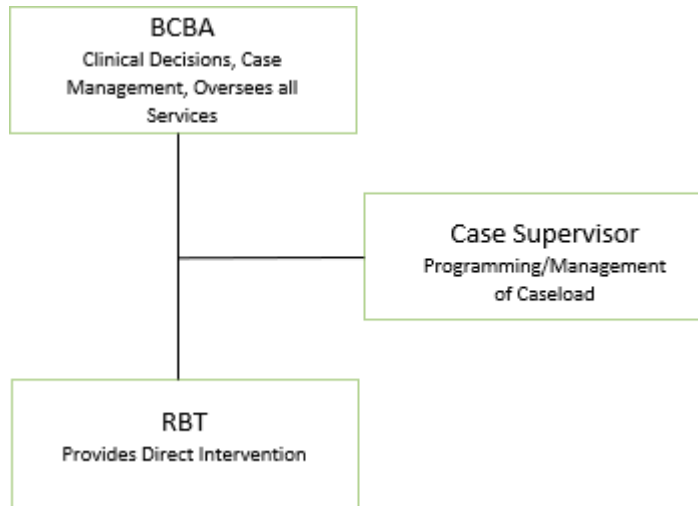
A breach of the following code of conduct (i.e., any one or more of the following) is subject to immediate discharge of services and referral to a different provider:

- Caregiver forces a dual/multiple relationship [i.e., “A multiple relationship is one in which a behavior analyst is in both a behavior-analytic role and a non-behavior-analytic role simultaneously with a client, supervisee, or someone closely associated with or related to the client” (“Professional and Ethical Compliance Code for Behavior Analysts, Behavior Analyst Certification Board, 2014)] with a Sunderlin Behavioral Staff Member.
- Caregiver acts belligerent, disrespectful, and/or threaten to cause harm (physical or verbal) towards a Sunderlin Behavioral Staff Member via phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication.
- Caregiver uses profanity or take belligerent tone when communicating with any Sunderlin Behavioral Staff Member.
- Caregiver targets a staff outside of company agency policies.

** Caregiver is responsible for his/her actions (e.g., inform the team if the treatment plan is not understood). If treatment is not followed as advised by the treatment team, results may vary*

Tier Model

We utilize a three-tier treatment delivery model, which entails the following, with the BCBA overseeing all services:



By signing below, I have read and acknowledge the Code of Conduct and Tier Model:

Parent/Guardian Signature: _____

Date: _____



Discharge of Services

Individuals can be discharged from services for failure to comply with policies of Sunderlin Behavioral Intervention. The following will result in discharge of ABA services.

- Data demonstrates that services have been effective, and the acquisition program and objectives have been reached significant enough to decrease the existing developmental gap.
- Data demonstrates that the services have not been effective, as determined data collection.
- There have been repeated missed appointments and/or lack of caregiver supervision.
- Parent / primary caregiver(s) chooses to stop services or desires another type of intervention.
- Failure to comply with more than 80% of the recommended ABA plan of treatment by the BCBA provider.
- Failure to adhere to the home expectations checklist located in the Work environment section of the service delivery agreement
- If you should have an outstanding balance more than 15 days.
- 30-day notice will be given to families with Private insurance policies
- 60-day notice will be given to families with State funded insurance polices

By signing below, I am acknowledging that I have read and understand the terms and conditions.

Parent/Guardian Signature: _____

Date: _____



Agency Closures Schedule 2022

New Year's Day: Friday, January 1, 2022

Memorial Day: Monday, May 30, 2022

Independence Day (observed): Monday, July 4, 2022

Labor Day: Monday, September 5, 2022

Thanksgiving Day: Thursday, November 24, 2022

Day after Thanksgiving: Friday, November 25, 2022

Christmas Eve: Saturday, December 24, 2022

Christmas Day (observed): Monday, December 26, 2022

New Year's Eve: Saturday, December 31, 2022

New Year's Day (observed): Monday, January 2, 2023



Sunderlin Behavioral Interventions Grievance Policy

Name of Family Member: _____ **Date of Birth:** _____

Sunderlin encourages parents to try to resolve their concerns about our services informally, we also recognize that some concerns will not be resolved in that manner and may require formal investigation and resolution.

Please first speak to your Case Supervisor openly about your concerns. Please do not discuss your concerns with your Behavioral Therapist. The formal Grievance Procedure described below should be used to address concerns about your family member services that are not resolved formally. Allegations of abuse, neglect, exploitation or misappropriation of funds should not be addressed through the grievance process. Rather, such issues should be reported directly and immediately to the Clinical Director.

At any time during this process, you may contact your health plan or any other advocacy organization for assistance. A list of team members with the contact information will be provided to you at the beginning of treatment.

1. Any service-related problem which you wish to have considered as a grievance should be described in writing and submitted to your Case Supervisor. The Case Supervisor will respond to you in writing within five (5) business days. Your Case Supervisor is obligated to assist you with the writing and submission of a grievance if you need assistance. If your concerns are related to a violation of rights of privacy, please contact the Case Supervisor immediately. All personal rights issues will be investigated immediately.
2. If the Case Supervisor does not resolve the grievances to your satisfaction, you may submit a written statement of the grievance to the Founder/Clinical Director within fifteen (15) business days following receipt of the Case Supervisor's written response. The determination of the Founder/Clinical Director shall be the final.
3. At any time during the process, you may submit a grievance to your health plan.
4. No form of retaliation shall occur nor shall any barrier to service be created because of the grievance.
5. All documentation regarding the grievance will be filed in the case record.
6. When any program related concerns are informally resolved, Sunderlin will include summary information about the resolution on the outcome measures reports.
7. The grievance process does not apply to denial or limitations of service issued by your health plan. Denials or limitations of services issued by the health plan must be appealed directly to the health plan.



Sunderlin Behavioral Interventions Grievance Policy

(Continued)

Any and all controversies, claims, or disputes (collectively “Disputes”) arising out of or related to your relationship with Sunderlin or the services we provide for you or your child, which cannot be resolved pursuant to the Grievance Procedure, including the interpretation of the documents contained in the Intake Packet and the scope or applicability of this agreement for dispute resolution, will be resolved according to the following procedures.

1. **Binding Arbitration:** You agree to proceed to final and binding arbitration (“Arbitration”), before a single neutral arbitrator, conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as modified herein. You or we may initiate Arbitration via a written notice (“Arbitration Notice”), which must be delivered no later than thirty (30) days following the conclusion of Mediation. The Arbitration will take place in Agoura, California. We will have thirty (30) days from the date of the Arbitration Notice to jointly agree on an arbitrator to conduct the Arbitration. The arbitrator will follow California law in adjudicating the dispute. In the event we cannot agree on an arbitrator, we shall each select an arbitrator, affiliated with JAMS, who will jointly select a third arbitrator who will ultimately adjudicate the Dispute. The arbitrator will provide a detailed written statement of decision, which will be part of the Arbitration award and admissible in any judicial proceeding to confirm, correct or vacate the award. The prevailing party will be entitled to all fees and costs associated with Arbitration (or enforcement of an award therefrom), including, but not limited to, reasonable attorney’s fees, from the other party upon completion of the Arbitration.

2. **Class Action Waiver:** You hereby agree that the Arbitration of any Dispute will take place on an individual basis and will not include any form of class or representative action (“Class Action”) and you hereby agree to waive any Class Actions related to a Dispute (“Class Action Waiver”). You hereby acknowledge and agree that any claim you submit to Arbitration will be on your own behalf and you will not seek to represent the interest of another person or entity. If this Class Action Waiver is held to be unenforceable under applicable law, then it will be excluded from this Dispute Resolution Agreement, the balance of this Dispute Resolution Agreement and any other documents contained in this Intake Packet will be interpreted as if this Class Action Waiver were so excluded, and the balance of this Dispute Resolution Agreement and any other documents contained in the Intake Packet will be enforceable according to their terms.

Parent/Guardian Signature: _____

Date: _____



CreditCard Authorization

For Recurring Payment with Debit/Credit Cards

I authorize Sunderlin Behavioral Interventions to keep my signature on file to charge my debit/credit card, on an ongoing basis, for amounts I owe. I understand that I will only be charged for services that have been verified by the legal guardian who is present while the services are being delivered.

Type of debit/credit card (check one): American Express Visa
 MasterCard Discover

I understand that this authorization is valid indefinitely unless I cancel the authorization through written notice. I also agree to contact the Company if there are any changes to my charge account information.

(Please complete the form below)

Child's Name: _____

Parent's Name (accountholder's name): _____

Date to begin debit/credit card payment: ____/____/____

Cardholder Billing Address:

Address

City

State

Zip

Card Account Number

CVV (3 digit)

Exp. Date – Mo/Yr

By signing this form electronically, you are agreeing to the terms noted above.

Card Holders Signature: _____ Date: _____

Child's Name: _____ DOB: _____