



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
- Child Availability Form
- 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:

- 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:

7140 SW Fir Loop Suite 105
Portland OR, 97223-8062
Phone: (971) 249-3791
Fax: (805) 823-4462

[Intake.sunderlinbcb@gmail.com](mailto:intake.sunderlinbcb@gmail.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 (971) 249-3791

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 videotaped, for the purpose of clinical documentation. Such tapes may only be shared with Sunderlin Behavioral Interventions staff and above named professionals or agencies for which there is a release of information. I further understand that according to the Family Rights Act, my permission to video tape shall not exceed 6 months duration from the time the consent is signed.

Initial: _____ Yes No Date _____



I give permission for my child to be videotaped, for the purposes of training and education. Such tapes may be used Sunderlin Behavioral Interventions staff trainings and community trainings provided by Sunderlin Behavioral. I further understand that according to the Family Rights Act, my permission to video tape shall not exceed 6 months duration from the time consent is signed.

Initial: _____ Yes No Date _____

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: _____



MEDIA RELEASE FORM

You have been asked to provide consent for Sunderlin Behavioral Interventions to photograph and/or videotape your child, _____, engaged in a therapy session with our staff. With your permission, we may utilize the photograph and/or video recordings on our company website and/or social media site (Facebook, twitter, etc....) for showing what a typical therapy session looks like at our clinic. Any photograph and/or video recordings that may be used on our company website and/or social media site will only show your child in a positive and respectful manner (e.g., fully engaged with the therapist and enjoying the session). You and your child’s individual privacy will be maintained, and you have the right to view and approve any photograph and/or videos prior to the inclusion of a photograph and/or video on our company website and/or social media site upon your request.

Sunderlin Behavioral Interventions would also like to ask for your permission to use photograph and/or video record for research and/or presentation for the sole purpose of educating others on therapy within our company. Please indicate which uses you consent to by initialing below. You are free to initial any number of spaces, from zero to all the spaces, and your response will in no way affect you or your child’s current or future treatment. You also have the right to revoke your permission for us to use photographs and or/videos of your child at any time by writing a letter stating so. Sunderlin Behavioral Interventions will honor your request without any negative affect on your child’s current or future treatment. Photographs and/or video recordings will remain securely stored in a secure data system on company premises. If you would like a copy of your child’s video, this can be provided upon your request.

I give permission for portions of photographs and/or videotaped treatment sessions to be shown on Sunderlin Behavioral Interventions website and or social media site.

Initials: _____

I give permission for portions of photograph and/or videotaped treatment sessions to be shown during educational and/or research presentations.

Initials: _____

I give permission for portions of photograph and/or videotaped treatment sessions to be shown for clinical or medical record review through HIPAA compliant software.

Initials: _____



I have read the above description and give my consent for the use of photographs and or videotapes as indicated above.

Print Your Child’s Full Name

Signature parent/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 (805) 230-3701 Address 30343 Canwood St Suite 100, Agoura CA, 91301.

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 30343 Canwood St. Suite 100, Agoura Hills, CA 91301. 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 \$35 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 **\$25 cancellation fee**

No Show Policy:

If an appointment was scheduled **AND** not cancelled, in that instance, a **“no show” fee of \$50.00 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.

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: _____

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 for services in the chart below. The more availability you provide, the better we will able to plan for your child and schedule services.

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	

Intake Form for Clients

Client Information



Intake Form for Clients

Client Information:

Last*

First*

Middle



Address*

Apartment Number

City*

State*

Zip*

Female

Date of Birth: *

Diagnosis:

Sex: * Male

Primary Guardian Information:

Email Address*

Last*

First*

Middle

Address: *

Apartment Number

City*

State*

Zip*

(____) _____

(____) _____

Relationship to Client*

Primary Phone Number*

Secondary Phone Number

____ / ____ /

Employer

Date of Birth

Social Security Number*

Insurance Information:

Primary Insurance Company*

Policy ID#*

Group #*

Primary Insurance Phone Number*



Secondary Insurance
Company

Policy ID#*

Group #*

Service Offerings:

Services Interested in (Check all that apply):

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

If interested in school services, please answer the following:

School Name: _____ **School District:** _____

School Address: _____ **State:** _____ **Zip code:** _____

Name of Teacher/Director: _____ **Phone Number:** _____

Behavioral Concerns:

Please list current behavioral concerns for the client:

Pediatrician Information:

Pediatrician Name: _____ **Phone:** (_____) _____
_____ **Fax:** (_____) _____

How Did You Hear About Us? (Check all that apply)

- ALP Website Facebook
- Community Event Other: _____

If a doctor or friend referred you to us, please tell us who:

Credit Card 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 –

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

_____ / ____/____

Cardholder Signature

Date

Child's Name _____

DOB: _____

Medical History

Are Immunizations up to Date: Yes No

**Medication Allergies:
Patient History Questionnaire**

PLEASE CHECK IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

<input type="checkbox"/> Ear	<input type="checkbox"/> Heart	<input type="checkbox"/> Kidney	<input type="checkbox"/> Muscle
<input type="checkbox"/> Infections	<input type="checkbox"/> Problems	<input type="checkbox"/> Problems	<input type="checkbox"/> Disorders
<input type="checkbox"/> Headaches	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Endocrine Disorders	<input type="checkbox"/> Scoliosis

Vision Problems	Asthma	Diabetes	Skin Problems
Hearing Problems	Respiratory Problems	Thyroid Problems	Anemia
Meningitis	Constipation	Arthritis	Seizures

LIST CURRENT MEDICATIONS:	DOSE:	REASON:

Family History

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT ARE OR HAVE BEEN PRESENT IN THE CHILD'S IMMEDIATE OR EXTENDED BIOLOGICAL FAMILY: _____

	SIBLINGS	MOTHER	FATHER	MOTHER'S RELATIVES	FATHER'S RELATIVES
Developmental Delay					
ADHD					
Mental Retardation					
Learning 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:					

Applied Behavioral Applied Questionnaire

**HAS YOUR CHILD RECEIVED
PRIOR ABA SERVICES? YES NO**

If yes, please provide name OF PROVIDER and how long your child was receiving ABA?

**HAS YOUR CHILD BEEN DIAGNOSIS WITH AUTISM, PDD-NOS, ASPERGER'S?
RETTS OR CDD?**

IF SO, PLESAAE PROVIDE LICENSED PROVIDER INFOTMATION.

PROVIDER NAME:

PROVIDER ADDRESS:

PROVIDER PHONE NUMBER:

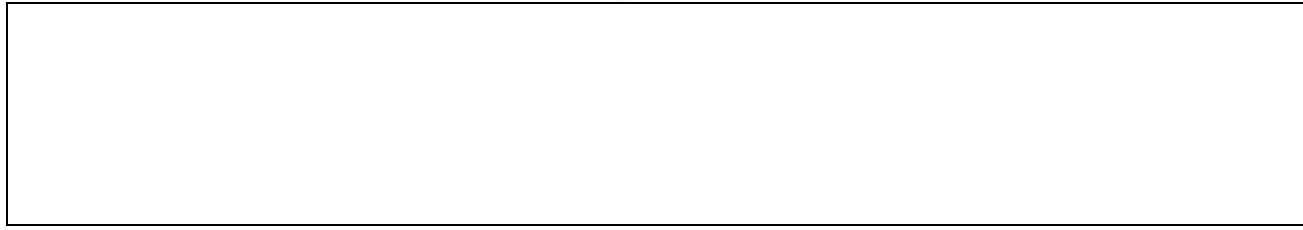
PROVIDER NPI:

**ARE THERE ANY FAMILY OR LEGAL ISSUES (DIVORCE, CHILD CUSTODY, ETC.)
IF SO, PLEASE DESCRIBE BRIEFLY.**

**ARE THERE ANY SPIRITUAL/CULTURAL BELIEFS THAT WOULD INTERFERE
WITH RECEIVING ABA TREATMENT?**

IF SO, PLEASE EXPLAIN:

NOTES:



A Caregiver's Guide to Autism Services

Each Participant's treatment program is designed and implemented with his/her individual abilities, needs, cognitive level, and learning style in mind, integrating treatment methodologies which are empirically demonstrated to be effective for an individual with a similar profile.

Program Philosophy

All services and programs by Sunderlin were developed and implemented based upon needs and the agency's mission statement: Sunderlin Behavioral Interventions LLC maintains the philosophy that quality treatment is defined by high ethical standards and compassionate attention to detail. We believe that educating the caregiver is just as important as creating cutting edge behavioral programs for our clients. As a smaller, private agency with a great deal of experience, we can offer more personalized services.

Our area of expertise is to provide behavior management, by using Positive Behavior Support strategies to achieve long lasting behavior change. This evidence-based approach uses a collaborative model by combining Behavior Analysis, Person-Centered Values and Systems Change ("It takes a village...") to enhance an individual's quality of life.



Integrity: We conduct business ethically and with a commitment to personal integrity. We expect people to hold a high standard of honesty and truth. When faced with an ethical dilemma, we do what is right.

Respect: We respect everyone and treat all with dignity and equality. We value the uniqueness and dignity of each individual and appreciate the strength of diversity and inclusion.

Shared Purpose: We share a sense of purpose. We have an enthusiastic sense of mission. We believe we must work as a unified organization in a highly effective manner to better meet our mission.

Excellence: We value excellence. We value people who get involved and show a sense of urgency. We believe it takes excellent, confident and accountable people to create innovative solutions that are valued by the people we serve.

Quality: We commit ourselves to achieve the highest level of quality. It is critical to accomplishing our purpose statement successfully. Quality, responsive, individualized services are designed to enhance safety, wellness and quality of life.

Community: We support everyone's right to live, work and play in the community. We promote choices by providing support, awareness and opportunities.

Customer-focused: We are customer-focused. We value to strive, continually understand and proactively respond to the increasing changing needs of the people we serve and to promote equality, dignity and independence.

Sunderlin Behavioral Interventions as an agency has ongoing experiences and programs for individuals who have developmental disabilities in a variety of different programs that reflect the specific needs of individuals and of the community. Sunderlin Behavioral believes that the intensity and quality of treatment directly relates to the positive treatment outcomes of our participants.

Sunderlin Behavioral measures progress by participants ability to demonstrate skills in a natural and spontaneous manner across people, settings, material, and routines. Research indicates that individuals who only demonstrate targeted skills with a high level of adult prompting and instructed activities may not "generalize" these skills to their daily routines. It can appear that a participant is making rapid progress under such high controlled conditions. However, for a participant's long-term success it is critical they initiate and sustain independent, active participation in daily interactions and social activities. Therefore, we would not consider a goal "met" until a participant demonstrates the targeted skills spontaneously or independently across typical everyday activities, routines, and social interactions. Although, the therapy schedule may seem demanding, limited treatment time will reduce the number of learning opportunities which may increase the developmental gap and the time it takes to meet your treatment goals.

Comprehensive ABA Treatment

Our comprehensive treatment model is recommended when the goal is to close the gap between the participant's overall level of functioning and that of typically developing peers. This model addresses skills



across all areas of development including language, play, social interaction, joint attention, imitation, motor skills, self-care, and behavior. Teaching occurs through a combination of structured and play-based teaching opportunities. We also use function behavior assessment and communication training to address behavioral challenges. These intensive programs tend to range from 25-40 hours of direct therapy plus supervision per week.

Focused ABA Treatment

Our focused treatment model is recommended when there are a limited number of treatment areas. Generally, this model addresses functional skills in the areas of health and safety, self-care, independent leisure, and socialization. In addition, the program will focus on reducing dangerous, or understanding behavior while increasing functionally equivalent alternative behaviors. These programs tend to range from 10-25 hours of direct therapy plus supervision per week.

Caregiver ABA Training

Our caregiver training model is recommended as we transition from focused treatment to parent-directed support. In addition, this model may be recommended as a booster to a previous receipt of behavioral services. Caregiver training may be recommended for those who are not ready or available for more intensive treatment.

These services are home-based, community-based format. Caregiver participation is required to maximize the therapeutic benefit for the participant and to ensure generalization of skills.

Other services

Sunderlin also offers Adult Life Coaching, Consultation, Functional Behavior Assessments, Workshops and Parent Training services in addition to group-based classes focused on social and adaptive skills. Our therapists work as an integrated part of our interdisciplinary team and are available to teams for periodic consultation services on a case-by-case basis. Additionally, when authorized, our therapists can provide individual services to a participant as an integrated part of the intervention team.

Medically Necessary and Educationally Necessary Intervention

Medical necessary service applies only to services funded through a health insurance company. Medically necessary services are designated to facilitate developmentally appropriate functioning in the areas of expressive and receptive language, language pragmatics, self-help daily living skills and to address developmentally inappropriate behaviors which are a barrier to developmentally appropriate self-help daily living skills. Medically necessary services are also appropriate to address behaviors which pose a significant risk to the personal safety of the individual or others. Medical necessary services are not appropriate to address skills and knowledge necessary for accessing educations, vocational, or employment settings. Often there is significant overlap between educational and medical services. However, because medical necessary services do not address core academic skills such as reading and mathematics, except within the context of other functional skills (e.g., reading street signs or paying for items at a store), it is critical for your family member to receive both medical and educational services in a collaborative fashion. This collaboration includes verbal or written communication with your medical and education team members. It does not entail providing services in the educational setting.

Session Structure

Applied Behavior Analysis

Upon your Behavioral Therapist arrival, her or she will greet you and your family member and begin to set up materials. This is a great time to check in with the Behavioral Therapist about how the family member's day has been going. The Behavioral Therapists will benefit from knowing if your family member is feeling well and has eaten and slept well in the last 24 hours. Also, let them know about unusual events in your family member's life, as well as recent successes and challenges you may have encountered. All this information will assist the Behavioral Therapists adjust his/her daily teaching plan to meet your family member needs.

Sessions are guided by treatment plans that have been developed specifically for you and your family member based on treatment goals. These plans are guidelines for the Behavioral Therapist about how particular goals will be achieved during various activities.

Periodically throughout a session, the Behavioral Therapists will offer a break (engagement in a self-directed, productive activity). During this time the Behavioral Therapist will take data and organize additional teaching materials.

We prefer to teach in the natural environment. This may include several areas of your home where the activities we are teaching naturally take place (living room, kitchen, bedroom, bathroom, playroom, etc.), as well as the community (park, neighborhood walks, stores, mommy and me classes, community center activities, clinic-based playgroups, etc.). We will discuss the specific location of intervention with you throughout your family member's program. To appropriately generalize treatment goals, we generally recommend sessions across different environments.

In the last 10-15 minutes of the session the Behavioral Therapists will clean up, write a session note about the session, finish data collection, take the time to answer questions you might have and discuss the session. At the end of every session the Behavioral Therapists will ask you to sign the attendance log documenting the day and what you might work on outside of therapy sessions. Should you have any questions or concerns about the concerns about the content of these notes, please feel free to contact the Case Supervisor.

Staff Training

Applied Behavior Analysis

In order to maintain our commitment to exceptional services, initial and on-going Behavioral Therapist training is required. This requirement includes overlaps or observations during your family member sessions. Overlaps may involve new associate or a staff trainer. In most case these overlaps are an opportunity for your family member to generalize skills that he or she is learning to a new person. If you have any questions about overlaps, please contact your Case Supervisor.

Communication

Applied Behavioral Analysis



Please check in with your family members Behavioral Therapist as often as you'd like about how the day went and how he/she is doing on treatment objectives. At the end of the session, Behavioral Therapists will direct you to session notes and program checklists that details information on the goals targeted that day. This is a great time to ask for additional information.

The Case Supervisors are responsible for the day-to-day supervision of your program. Their responsibilities include direct supervision activities performed at your home, such as providing feedback to staff during sessions, providing guidance to your family member's team, and parent/caregiver training. Additionally, they are responsible for indirect activities such as writing program goals and behavior plans, monitoring data, and drafting reports. Generally, you can expect that the Case Supervisor will be in your home on a weekly basis. Case Supervisors are available to discuss any specific concerns during regular business hours via phone or email. Additionally, Case Supervisors check in with you during their home visits and will schedule monthly clinical team meetings to discuss specific progress on your family member's treatment plan. In addition, your Case Supervisor may schedule additional sessions with you to provide parent training related to the treatment plan.

The Case Supervisors provide training and guidance to all the staff members. Much of their supervision time is conducted indirectly in the form of reviews and internal team meetings. This allows the Case Supervisors the ability to provide intensive staff training in specific to your family member on a regular basis. Generally, Clinical Supervisors provide direct supervision overlapping in-home sessions at least once per month. Each month the team members (Behavioral Therapist, Case Supervisor) meet with the family to discuss progress on the previous treatment plans. We do our best to schedule times where most of your team can be present for the meeting,

Therapy Services

- It is imperative to make ABA treatment a priority and schedule, extracurricular activities, and family functions, outside of session times. We hope to minimize cancellations by only reserving situations to client illness, staff illness or family vacations.
- Since we follow the medical model (3 tier system- Therapist, Supervisor, Clinical Director) there are procedures and programs that have to be done outside of session (depending on your funding source), to keep your child's treatment program up to date and will be billed as such.
- Outings in the community will be limited to 30 minutes to 1 hr. maximum and must be scheduled in advanced or approved as a contrived teaching opportunity, 1-2 times per week. With the exception of My gym, Karate, summer camp.
- We are to only provide ABA therapy and not to implement anything outside of our scope of practice.
- As a reminder we provide a mobile service and at times may be a few minutes late as we are coming to your home. If you experience your therapist arrives chronically late, please contact your case supervisor immediately, in order to address this and remedy the situation.

The last 15 minutes of each therapy session are reserved for communication between caregivers and our therapists. During this time the therapist may review your family members progress towards objectives. In



addition, the therapists will review how therapeutic techniques can be used in the home setting. Finally, this is a Behavioral Therapists opportunity to address any concerns with the acquisition of new skills.

Service Limitations

Our staff does not provide custodial care of any sort. A responsible adult over the age of 18 is required to be present during all the sessions regardless of location (home, school, daycare, community, etc.) Our staff cannot take primary responsibility for your family member during session either at home or in the community. Appropriate responsible adults can include parents, teachers, grandparents, nannies/babysitters, or any other adult who you have given authority to care for the health and welfare of your family member. This person will be responsible for most of the feeding, monitoring health, safety in the community, and bathroom routines unless a treatment goal explicitly calls for Behavioral Therapist involvement. Under these circumstances, the associate will work with the caregiver to implement the support strategy. Additionally, our associates are not able to provide transportation for your family member.

The Work Environment

Sunderlin Behavioral Interventions is under legal obligation to provide a safe and harassment free working environment for all of 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

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 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.

Signature of Parent/Guardian

Date



Caregivers' Code of Conduct

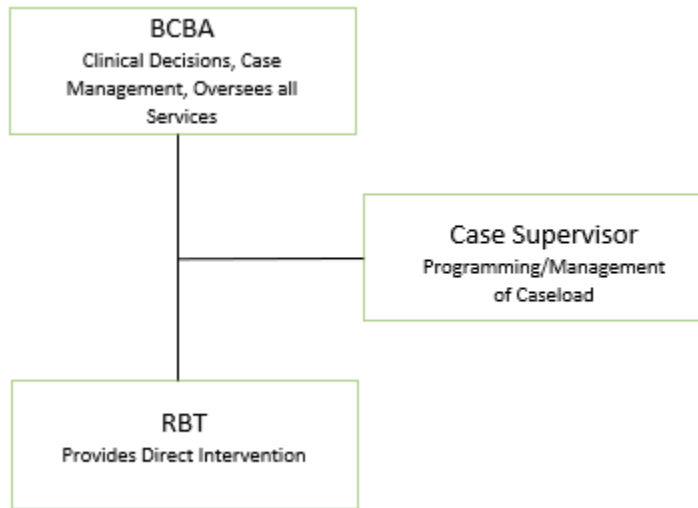
A breach of the following code of conduct (i.e., any one or more of the following) is subject to immediate discharge of services and referral to a different provider:

- 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:

Signature of Parent/Guardian

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.

Signature of Parent/Guardian

Date



Agency Closures Schedule 2021

- New Year's Day: Friday, January 1, 2021
- Memorial Day: Monday, May 31, 2021
- Independence Day (observed): Monday, July 5, 2021
- Labor Day: Monday, September 6, 2021
- Thanksgiving Day: Thursday, November 25, 2021
- Day after Thanksgiving: Friday, November 26, 2021
- Christmas Eve: Friday, December 24, 2021
- Christmas Day: Saturday, December 25, 2021
- New Year's Eve: Friday, December 31, 2021
- New Year's Day: Saturday, January 1, 2022



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.

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 Acton 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.

Signature of Parent/Guardian/Conservator

Date