Dear Parents/Legal Guardians,

Thank you for your interest in Community School and Community ABA clinic. Our mission is to positively impact the life of each child through our unparalleled commitment and desire to see our clients reach their greatest potential. Educational and therapeutic services are aimed at developing and improving your child's communications skills, increasing social interactions with others, expressing and coping with emotions and developing self-regulation strategies. Our educational philosophy is grounded in the principles of Applied Behavior Analysis (ABA). We believe that ABA teaches people *HOW* to learn most effectively, while education informs *WHAT* to teach. The two disciplines complement one another, maximizing the learning opportunities our learners encounter.

The information you provide within this packet will be utilized to inform the interdisciplinary team of your child's medical, educational, and therapeutic background. This critical information will help inform educational and therapeutic goals, as well as provide us with necessary information to secure authorization for treatment. It is important to complete all the sections thoroughly. The evaluation will guide the direction of treatment and ensure that the goals are appropriate for your child's optimal growth and development. The baseline information provides an accurate understanding of your child's current abilities, as well as a basis for comparison to measure progress in treatment over time.

This packet MUST be completed PRIOR to your child's first day of school and/or ABA therapy at Community School. Your child's file will become active once this packet and all additional required documents have been received and reviewed.

If you have any further questions or concerns, please contact us:

Toni Black
Administrative Assistant
Phone: 318-416-9603 ext. 4 Fax: 318-416-9604

Welcome to orientation.

Name: _____ **ID#:** _____ **Date Reviewed:** _____/_____/_____

Intake Checklists

Reviewed	Completed	Part A: Completed by ALL applicants
		ALL relevant formal evaluations, diagnostic assessment(s) & IEP/IFSP **(p. 3)**
		Medical Evaluation (Well-Child Check) **(p. 3)**
		Personal Information **(p. 5)**
		Medical History **(p. 6)**
		Emergency Plan / Information **(p. 7 - 8)**
		History of Therapies **(p. 9 - 10)**
		Parent / Caregiver Intake Questionnaire **(p. 11 - 17)**
		Permission to Photograph/Videotape/Audiotape **(p. 37)**
		Consent for Participation in Swim Program **(p. 38)**
		Tuition Agreement **(Back of packet) [*Exception: ABA only]**

Signed or Initialed	Part B: ONLY completed by applicants interested in ABA services
	Autism-specific Diagnostic Assessment **(p. 3)**
	Prescription for ABA services **(p. 3)**
	Copy of Insurance Cards [FRONT & BACK] **(p. 3)**
	Insurance Information **(p. 4)**
	General Information About Services **(p. 18 - 20)**
	Orientation to Services **(p. 21)**
	Program Description **(p. 22)**
	Client's Rights & Responsibilities **(p. 23 - 24)**
	Consent for Treatment & Recipient's Rights **(p. 25)**
	Authorization to Release information **(p. 26)**
	Authorization to Bill Insurance **(p. 27)**
	Human Rights Notification **(p. 28)**
	Client Grievance Procedures & Certification & Licensure Board Information **(p. 29)**
	How to Contact your Service Providers **(p. 30)**
	Privacy of Information Policies **(p. 31 - 33)**
	Confidentiality Act – Abuse-Reporting Protocol **(p. 34)**
	Freedom of Choice of Provider **(p. 35)**
	Functional Behavior Assessment (FBA) Consent Form **(p. 36)**
	Permission to Photograph/Videotape/Audiotape **(p. 37)**
	Consent for Participation in Swim Program **(p. 38)**
	Telehealth Practices & Protocols **(p. 39 - 40)**
	Informed Consent for Restrictive Procedures **(p. 41)**
	HIPPA Service Agreement & Consent Form **(p. 42 - 44)**

Thank you for your patience and diligence. We'll get through this part. Remember, it is important to know and understand what you are agreeing to. Partnership requires clear understanding. Ask all the questions!

Evaluations, Assessments, & Other Required Documents

ABA + Edu	ABA Only	Edu Only	**The following reports are REQUIRED as a part of enrollment application -- if indicated in column for type of service(s) you are requesting [(ABA + School) (ABA Only) (School Only)]**
X	**X**		**Autism-specific Diagnostic Assessment:** (Please include all previous evaluations) • Comprehensive assessment that includes the use of a variety of diagnostic tools (CARS, ADOS, etc.) designed to evaluate specifically the symptoms/core deficit areas of autism spectrum disorder • This evaluation can be completed within either a Psychological Evaluation or a Speech/Language Assessment
X	**X**		**Prescription for ABA Services:** • Call your child's pediatrician & request they fax the ABA prescription to Community School • **Fax #:** 318-416-9604
X	**X**		**Medical Evaluation (Well Child Check):** • This is an examination by a *licensed physician* • Must be completed within the last 12 months
X	**X**		**Insurance Card(s):** • Submit a copy of the FRONT and BACK of **ALL** insurance cards by email, mail or fax

	Please include any of the additional reports below if applicable -- Only the most recent evaluations are needed
	Comprehensive Speech/Language Evaluation – this is an evaluation by a *licensed Speech/Language Pathologist*
	Occupational Therapy Evaluation - this is an evaluation completed by a *licensed occupational therapist*
	Physical Therapy Evaluation – this is an evaluation completed by a *licensed physical therapist*
	Feeding Therapy Evaluation – this is an evaluation completed by a *licensed occupational therapist or speech and language pathologist*
	Individualized Education Plan – Individualized Education Plans (IEP) or Individualized Family Service Plans (IFSP) • **ALL** are requested, as these documents demonstrate learning patterns and skill acquisition across time
	* **Any Other** Formal Evaluation(s), Diagnostic Assessment(s), Genetic Testing Results – to help inform treatment planning

- Previous evaluations and assessments conducted by medical and other therapeutic practitioners include important information needed to request **Authorization of ABA Services** from insurance providers and help inform treatment planning.
- Individualized treatment plans will be developed by Community School interdisciplinary team based on records review, direct observation of the learner, and a parent / caregiver interview. Community School is not required or obligated to follow IEPs or IFSPs developed by public school providers.

Parent / Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Child: _____

Insurance Information

Client Information		
First Name	Last Name	Middle Initial

Medicaid (Write "N/A" if your child does not have Medicaid)

Your Child's Medicaid Managed Care Organization (MCO):

☐ Louisiana Healthcare Connections (LHCC) ☐ Aetna ☐ Healthy Blue ☐ AmeriHealth Caritas

☐ Amerigroup Louisiana ☐ Healthy Humana ☐ Other _____

Your Child's Medicaid Number:

Has your child completed the **TEFRA** process? ☐ Yes ☐ No

Primary Insurance		
Name of Primary Insurance Company		
Contract #	Group #	ID #
Insurance Policy Holder	Relationship to Client	
Date of Birth (Insured)	Employed by	Occupation
Business Address		Business Phone

Secondary Insurance		
Name of Secondary Insurance Company		
Contract #	Group #	ID #
Insurance Policy Holder	Relationship to Client	
Date of Birth (Insured)	Employed by	Occupation
Business Address		Business Phone

Child's personal information:					
First Name	MI	Last Name	Gender ☐ Male ☐ Female	Date of Birth	Age ____ years ____ months

Home Address	City	State	Zip Code	Parish
Mailing Address (if different)	City	State	Zip Code	Parish

Child's Race and Ethnicity:		
Check all that apply	☐ Asian ☐ African-born ☐Black or African-American ☐White ☐ American Indian/Native Alaskan ☐ Pacific Islander/Native Hawaiian ☐ Other (specify) _____ ☐ Prefer not to answer	Hispanic or Latino? ☐ yes ☐ no

Parent/Guardian 1: Is parent 1 the legal guardian? ☐ Yes ☐ No				
First name	Last Name	Relationship to Child	Home Phone	Cell Phone
Is parent 1's address the same as child's? ☐ Yes ☐ No - if no, fill in below				
Home Address	City	State	Zip Code	
Email for Parent/Guardian 1	Parent/Guardian Occupation			

Parent/Guardian 2: Is parent 2 the legal guardian? ☐ Yes ☐ No				
First name	Last Name	Relationship to Child	Home Phone	Cell Phone
Is parent 2's address the same as child's? ☐ Yes ☐ No - if no, fill in below				
Home Address	City	State	Zip Code	
Email for Parent/Guardian 2	Parent/Guardian Occupation			

Diagnostic Information:		
What is your child's primary diagnosis?		
Date your child was first diagnosed?	Licensed Mental Health Professional / Physician who gave diagnosis	
Agency Name	Phone Number	Fax Number
Date of Last Evaluation (include copy of evaluation):	Current ☐ yes ☐ no	Last 12 months ☐ yes ☐ no

Medical History

Primary Care Provider:			
Name	Title		
Clinic Name	Phone Number	Fax Number	
Agency Street Address	City	State	Zip Code
Date Last Seen:	Anticipated Next Visit:		

Medical history:	
Hospitalizations	☐ yes ☐ no If yes, please describe and provide a date: _____
Surgery	☐ yes ☐ no If yes, please describe and provide a date: _____
Seizures	☐ yes ☐ no If yes, please describe when the seizures began and when the most recent one occurred:
Head Injuries/Loss of Consciousness	☐ yes ☐ no If yes, please describe and provide a date: _____
High Fevers	☐ yes ☐ no If yes, please describe and provide a date: _____
Other	

Prior Medical Evaluations:			
Evaluation Performed	**Date**	**By Whom**	**Reason/Result**
Well child check/annual physical			
Social Emotional screening			
Developmental screening			
Hearing			
ENT/Allergies			
Neurology			
Genetic Testing			
Other:			

Are immunizations current? ☐ yes ☐ no If no, describe reason:

Emergency Plan/ Information (Page 1 of 2)

Client's Name: _____

Emergency contacts other than parents/guardians:		
Contact #1: Name	Relationship to Child:	Phone Number:
Contact #2: Name	Relationship to Child:	Phone Number:

The following people are authorized to pick up:		
Name	Relationship to Child	Phone Number

The following people are restricted from contact with your child:	
Name	Relationship to Child / Additional Comments or Notes

**Please note a separate client release form needs to be filled out for the individuals noted for the emergency contacts and those who are able to pick up your child. See client release of information form at the end of the enrollment packet. **

Emergency Plan / Information (Page 2 of 2)

Dentist:			
Name of Dentist:	Name of Clinic:		Phone number:
Address	City	State	Zip Code

Child's Physician:			
Name of Physician:	Name of Clinic:		Phone number:
Address	City	State	Zip Code
Transport to which Hospital?		City	

Current Medications (include additional sheets as necessary):

Does child take medications ☐yes ☐no - If yes, list below

Medication	**Dosage**	**Frequency**	**Reason for Use**	**Needs to be Administered by Staff during session times** *(*Complete medication administration form for each medication checked "yes")*
				☐ **yes** ☐ **no**
				☐ **yes** ☐ **no**
				☐ **yes** ☐ **no**
				☐ **yes** ☐ **no**

Allergies (include additional sheets as necessary):

Does the child have allergies? ☐Yes ☐No ☐ Don't know

If yes, explain type of allergy and reaction, including any medication

Allergy	**Reaction**

Emergency action plan for seizures & allergies:

Child has a seizure history: ☐ yes ☐ no

Emergency Plan: 911 will be called if:

- Seizure lasts longer than _____ minutes (if the seizure lasts longer than 5 minutes, 911 will be called unless a note is provided from the doctor stating otherwise)
- Your child is having difficulty breathing
- Vomitus is aspirated
- A significant injury occurs during the seizure
- Status epilepticus occurs (continuous seizure)

Describe your child's typical seizure. What do you want Community School staff to do (other than routine first aid) if your child has seizure while at the center?

Call Parent when:

Call Physician when:

History of Therapies Received

ABA Therapy:	☐ Has not previously received ABA Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (If applicable)	
Agency/Clinic Name		Fax number	
Agency Street Address	City	State	Zip Code

Speech Therapy:	☐ Has not previously received Speech Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (If applicable)	
Agency/Clinic Name		Fax number	
Agency Street Address	City	State	Zip Code

Occupational Therapy:	☐ Has not previously received Occupational Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone number	
Frequency	Date Started	Date Discharged (If applicable)	
Agency/Clinic Name		Fax number	
Agency Street Address	City	State	Zip Code

Case management services:	☐ Has not previously received Occupational Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Service	Contact Name	Agency/County	Phone Number
Social Worker / Case Manager			
Other:			

History of Therapies Received

Feeding Therapy:	☐ Has not previously received Feeding Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone Number	
Frequency	Date Started	Date Discharged (If applicable)	
Agency/Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code

Physical Therapy:	☐ Has not previously received Physical Therapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone Number	
Frequency	Date Started	Date Discharged (If applicable)	
Agency/Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code

Psychotherapy (Family or Individual) Services:	☐ Has not previously received Psychotherapy ☐ Previously received services (List below) ☐ Currently receiving services (List below)		
Practitioner Name	Credentials	Phone Number	
Frequency	Date Started	Date Discharged (If applicable)	
Agency/Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code

Other:			
Practitioner Name	Credentials	Phone Number	
Frequency	Date Started	Date Discharged (If applicable)	
Agency/Clinic Name		Fax Number	
Agency Street Address	City	State	Zip Code

Parent / Caregiver Intake Questionnaire

Pregnancy and Delivery:

Describe if the pregnancy was typical or atypical:

Was the pregnancy full term? ☐ yes ☐ no Birth weight: _____pounds _____ounces

If no, please describe the length of the pregnancy:

Describe if labor and delivery was typical or atypical:

Was your child hospitalized after birth and/or admitted into NICU? ☐ yes ☐ no
If yes, for what and for how long:

Developmental Milestones:

If your child has hit these milestones, please list the age at which the child exhibited the following skills**.**

If they have yet to achieve these milestones, please put N/A**:**

Babbling _____
Combing Words _____
Rolled Over _____
Crawling _____
Walking _____
Use Utensils_____
Dry throughout the night _____
Brush teeth independently _____
Fasteners on clothing _____
Bathing self _____
Washing hands _____

First Word _____
Complete sentences _____
Sitting unsupported _____
Standing _____
Eating Table foods_____
Toilet trained _____
Sleeps throughout the night _____
Dress self _____
Tying Shoes _____
Brushing hair _____

Please list any sensory concerns for your child:

Has your child ever gained skills and lost them? ☐ yes ☐no If yes, please explain:

Tell us about your child:

Initial Concerns:

Date/ Age symptoms were first noticed:	Describe symptoms:
Who noticed the symptoms:	

Significant Events:
Describe any child or family events which may have impacted the child's development (*e.g., illness, medical issues, changes in family living situation, death of a family member, etc.)*
Child's Strengths:
What does your child do well?

Check the box in each domain that best describes your child:

Expressive Communication	☐ Able to spontaneously verbally express ideas and needs at a level appropriate to the child's age.	☐ Some spontaneous verbal expression of simple familiar or rote phrases to communicate ideas or express needs.	☐ Limited spontaneous expression of single words, signs, gestures, and/or Picture Exchange Communication System (PECS) or other augmentative device to request items or basic needs.	☐ Child has no spontaneous functional communication strategies.
Receptive Communication	☐ Able to respond appropriately to familiar and unfamiliar verbal requests, at a level expected for age.	☐ Able to respond appropriately to simple familiar/rote verbal requests but has difficulty responding to unfamiliar requests.	☐ Limited responses to simple familiar requests even when paired with visual cues or gestures and is unable to respond even when paired with visual cues and gestures.	☐ Does not respond when spoken to or when words are paired with visual cues and/or gestures.
Cognitive Functioning	☐ Cognitive skills appear to be at or above age-appropriate level. No interference with age-appropriate activities and interpersonal and daily life functioning.	☐ Mild cognitive challenges present minimal interference with age-appropriate activities and interpersonal and daily life functioning.	☐ Moderate cognitive challenges interfere with age-appropriate activities and interpersonal and daily life functioning.	☐ Severe cognitive challenges interfere with all aspects of daily life including lack of age-appropriate activities and interpersonal and daily life functioning.
Safety	☐ Able to occupy self alone or with siblings safely for age-appropriate periods of time.	☐ Able to occupy self safely depending on activity but requires moderate level of supervision for child's age.	☐ Able to occupy self safely for brief periods of times but requires high level of supervision for child's age.	☐ Requires constant supervision to ensure safety.
Support Needed	☐ Needs no assistance in participating in age - appropriate activities.	☐ Able to participate in age-appropriate activities with minimal adult support and cues.	☐ Requires moderate level of adult support and cues needed to participate in age-appropriate activities.	☐ Requires constant adults support and cues to participate in all age-appropriate activities.

Behavioral Characteristics of Your Child (Check all that apply):

- ☐ Generally Happy / Flexible
- ☐ Shares Easily
- ☐ Repetitive Behavior
- ☐ Self-Abusive Behavior
- ☐ Cooperative
- ☐ Short Attention Span, Fidgety
- ☐ Impulsive / Distractible
- ☐ Tries New / Novel Activities
- ☐ Seeks Out Touch
- ☐ Inflexible / Resistant to Change
- ☐ Destructive / Aggressive
- ☐ Shy
- ☐ Plays Well with Others
- ☐ Poor Eye Contact
- ☐ Shares Attention with Others
- ☐ Easily Frustrated
- ☐ Withdrawn
- ☐ Avoids Touch
- ☐ Other: _____

Check the box in each domain that best describes your child:

Social Interaction	☐ Primarily initiates and responds to social interaction in a reciprocal manner appropriate to child's age. Generally, does not interfere with functioning.	☐ Some initiation and response to social interaction in a reciprocal manner appropriate to child's age depending on activity.	☐ Requires moderate levels of support to initiate and respond to others in a social manner.	☐ Needs constant 1:1 support to notice and socially initiate and respond to others.
Social Communication	☐ Primarily demonstrates integrated use of verbal and non-verbal communication appropriate to child's age. Generally, does not interfere with functioning.	☐ Some abnormalities in eye contact, body language, and use of gestures for communication purposes.	☐ Moderate abnormalities in eye contact, body language, and use of gestures for communication purposes.	☐ Total lack of facial expressions, body language, and gestures for communication purposes.
Restrictive, Repetitive Behaviors/ Interests	☐ Fixations, preoccupations, inflexibility, and/or hyper/ hypo reactivity to sensory input generally do not interfere with daily functioning.	☐ Fixations, preoccupations, inflexibility, and/or hyper/hypo reactivity to sensory input cause mild interference with daily functioning. Can be verbally re-directed.	☐ Fixations, preoccupations, inflexibility, and/or hyper/hypo reactivity to sensory input cause moderate interference with daily functioning. May need visual or physical re- direction.	☐ Fixations, preoccupations, inflexibility, and/or hyper/hypo reactivity to sensory input cause significant interference with daily functioning are extremely difficult to re-direct. Requires physical re-direction.
Self-Care Skills	☐ Able to perform most age-appropriate self-help skills.	☐ Requires some assistance or verbal/visual cues but performs some self-help skills independently.	☐ Requires moderate verbal, visual and hands-on assistance for most self- help skills.	☐ Requires constant hands-on assistance for all self- help and daily cares.
Challenging Behaviors	☐ Age-appropriate behavioral challenges in familiar and unfamiliar environments.	☐ Mild behavioral challenges in one or more familiar and unfamiliar environments.	☐ Moderate behavioral challenges across most familiar and unfamiliar environments.	☐ Severe behavioral challenges across all familiar and unfamiliar environments.

Communication (Check all that apply)**:**

☐ Does not talk
☐ Was late to start talking
☐ Uses only single words
☐ Talks seldom
☐ Hard to understand child's words
☐ Cannot make correct speech sounds (for age)
☐ Repeats sounds/words/phrases (echolalia)
☐ Tries hard to communicate
☐ Unusual pitch to voice (high or low)
☐ Talks too loud or too quiet
☐ Asks questions of others
☐ Uses lots of gestures
☐ Can communicate "yes" How? _____
☐ Can communicate "no" How? _____
☐ Initiates conversation
☐ Asks questions
☐ Asks for people
☐ Responds to questions
☐ Asks to do activities
☐ Talks about present about past or future

Receptive Language:

☐ Responds to name
☐ Can point to/pick up what you ask
☐ Can follow simple instructions
☐ Can understand what you are saying
☐ Can answer simple "WH" questions
☐ Other: _____

Child's current form of communication:

☐ Gesturing (pointing, looking, etc.)
☐ Crying / Tantrums
☐ Sounds (non-words; i.e., grunting)
☐ Pictures (PEC's)
☐ Sign Language
☐ Single words
☐ 2 to 4-word sentences
☐ 4 or more-word sentences
☐ Augmentative and Alternative Communication Device (AAC) (TouchChat app on i-pad, Dynavox, etc.)

Language:

What is primary language spoken at home?	☐ English ☐ Other (specify) _____	
Language Interpreter used? ☐ yes ☐ no	If so, what language?	Sign language interpreter used? ☐ yes ☐ no

Current living situation:

Child lives:	☐ home with family ☐ foster care ☐ group home ☐ other (describe) _____
Parents are:	☐ birth parents ☐ grandparents / other relative ☐ adoptive parents ☐ other _____
Parents are:	☐ married ☐ separated ☐ divorced ☐ other (explain) _____

Family Members:

List out sibling names and their age and briefly describe your child's level of interaction or relationship.

Family Strengths:

Describe your family's strengths *(e.g., strong support system, sustainable childcare, supportive faith-based community, etc.)*

History of Developmental Conditions or Mental Health Concerns in Other Family Members:			
Family History of:			
Anxiety	☐yes	☐no	If yes, whom _____
Substance Abuse	☐yes	☐no	If yes, whom _____
Autism	☐yes	☐no	If yes, whom _____
Bi-polar Disorder	☐yes	☐no	If yes, whom _____
Schizophrenia	☐yes	☐no	If yes, whom _____
Learning Disabilities	☐yes	☐no	If yes, whom _____
Developmental Delays	☐yes	☐no	If yes, whom _____
Other_____	☐yes	☐no	If yes, whom _____

Cultural Considerations:
Are there any cultural considerations that need to be taken into account or that we should be aware of ? *(e.g., faith-based communities)*

School Services:
Does your child attend preschool? ☐ yes ☐ no - If yes, what is the name of the preschool?
Does your child attend school? ☐ yes ☐ no - If yes, what is the name of the school and district?
If your child attends school, what is his/her educational placement? ☐ general education ☐ special education
Does your child have an Individualized Education Plan (IEP)? ☐ yes ☐ no
Does your child have an Individualized Family Service Plan (IFSP)? ☐ yes ☐ no
If yes to either of the last two questions, when was the IEP or IFSP last updated? (mm/dd/yyyy)
Case Manager / IEP Manager's name and contact information:

Current Concerns:

Social Skills:

Does your child show an interest in peers? ☐ yes ☐ no
Does your child engage in parallel play? ☐ yes ☐ no
Does your child engage in cooperative play? ☐ yes ☐ no
Does your child engage in age-appropriate toy play? ☐ yes ☐ no
What does your child do for fun? _____

_____

Does your child try to share his/her enjoyment with others? ☐ yes ☐ no
Does your child try to comfort others when they are hurt or sad? ☐ yes ☐ no
Does your child use a range of facial expressions? ☐ yes ☐ no

Communication Skills:

How does your child communicate his/her wants and needs? _____

_____

Is your child verbal? ☐ yes ☐ no
If yes: How many words does your child typically use at once? _____
Does your child ask for items verbally? ☐ yes ☐ no
Does your child spontaneously label items? ☐ yes ☐ no
Does your child ask questions? ☐ yes ☐ no
Does your child answer questions? ☐ yes ☐ no
Can your child engage in conversations? ☐ yes ☐ no
Does your child use gestures? ☐ yes ☐ no
Can your child follow instructions ☐ yes ☐ no
If yes: How many steps can he/she follow at once? _____
Does your child appear to understand what you are saying? ☐ yes ☐ no

Restrictive and Repetitive Behaviors:

Does your child become fixated on objects/activities? ☐ yes ☐ no
Does your child struggle with changes in routines? ☐ yes ☐ no
Does your child engage in repetitive toy play? ☐ yes ☐ no
Does your child display ritualistic behaviors? ☐ yes ☐ no
If yes, list out examples _____
Does your child engage in repetitive behaviors? ☐ yes ☐ no
If yes, list out examples _____

What does your child do when upset? _____

_____

What causes your child to get upset? _____

_____

How frequently does your child get upset? _____

_____

Does your child have safety awareness? ☐ yes ☐ no

Please list out any other concerns: _____

_____

_____

_____

Technology Available (Check all that apply)**:**				
☐ Smart Phone	☐ Laptop	☐ Tablet	☐ Desktop with Webcam / Speakers / Microphone	☐ Internet
☐ Android ☐ Windows ☐ iPhone / Apple	☐ MAC / Apple ☐ Chromebook ☐ Windows / Microsoft	☐ iPad / Apple ☐ Surface ☐ Android	☐ MAC / Apple ☐ Windows / Microsoft	☐ Reliable WiFi connection

Check the box in each area that best describes you as a parent:				
Confidence	☐ Understand the diagnosis and feel competent about meeting my child's needs.	☐ Understand the diagnosis BUT uncertain about how to meet my child's needs.	☐ Have difficulty understanding the diagnosis and meeting my/our child's needs.	☐ DON'T understand the diagnosis and DON'T know how to meet my child's needs.
Stress	☐ Experience Low to Moderate Stress and manage it well.	☐ Experience times of Moderate to High Stress BUT it is manageable.	☐ Have High level of Stress BUT usually have the capacity to cope with it.	☐ Have High level of Stress on a daily basis and struggle to cope with and manage the situation.
Perception of Quality of Life	☐ Low to Moderate Impact BUT manage it well. *(Level of impact child's disability has on quality of life)*	☐ Times of Moderate to High Impact BUT it is manageable. *(Level of impact child's disability has on quality of life)*	☐ High Impact BUT usually have the capacity to cope with it. *(Level of impact child's disability has on quality of life)*	☐ High Impact AND struggle to cope with / manage the situation. *(Level of impact child's disability has on quality of life)*

Parent/Caregiver Training Preferences:

At Community School, we provide parent / caregiver training as an opportunity to help generalize the skills learned during therapy and to help address challenges that you may be experiencing as a parent / caregiver. Please indicate your preferences for family training (e.g., individual, group, home, center, telemedicine) and your top priorities / areas of concern for your child's treatment plan.

Preferences (Format / Location): *(Check ALL that apply)*

☐ Individual ☐ Group

☐ Home ☐ Center ☐ Community ☐ Telemedicine

Parent Priorities:

1. _____
2. _____
3. _____

Parent(s) / caregiver(s) are required to participate in a **minimum of 1-hour of training EACH MONTH with your child's supervisor (BCBA or BCaBA).

_____ Initial to acknowledge that you understand the expectations & requirements

General Information About Community School Services

An Overview of Applied Behavior Analysis

ABA Therapy

Our team utilizes the learning principles of Applied Behavior Analysis (ABA) to develop individualized programs that target some or all of the following domains: cognitive, speech, language, executive functions, motor skills, adaptive, academic / school readiness, play and leisure skills, and social skills. Behaviors for reduction or elimination are also assessed, prioritized, and part of the learner's plan. Each individualized program is based on the child's strengths and work to decrease skill deficits. All functional behavior assessments or functional analyses require consent prior to the onset of assessment.

Applied Behavior Analysis is the study of the functional relationship between one's behaviors and their environment. Data is collected on the stimuli in the person's environment that elicits, increases, decreases, or maintains the child's behavior. The data is analyzed and an individualized ABA program is developed and implemented. As the child's treatment progresses, data is collected and analyzed frequently to determine treatment effectiveness. The goal of a behavior analyst is to utilize behavioral contingencies to help the person learn more functional skills that can replace undesirable behaviors and improve quality of life. Our team seeks to produce significant results, enabling the child to adapt to their environment, and thus, preparing them for a brighter future.

Individualized Programming Development

Each child is unique, and therefore, we believe it is our job to design a behavior intervention program that is individualized to your child's specific needs. Our Board-Certified Behavior Analysts (BCBAs) and Board-Certified Assistant Behavior Analysts (BCaBAs) continually assess each learner's needs and use evidence-based procedures founded in ABA to create a specialized program for each person. Our highly skilled staff are trained in a wide range of ABA methodologies and techniques and engage in frequent, on-going supervision. For those enrolled in our specialized school programs, our team of educators and developmental specialists participate in the selection of learning objectives, educational activities, and school-readiness skills.

Verbal Behavior

Verbal Behavior (VB) teaches language and communication using the principles of Applied Behavior Analysis and the theories of behaviorist B.F. Skinner. Verbal Behavior is the actions of a person that are reinforced by a listener. It is a way of understanding the different purposes of language (e.g., a child may use language to ask for things or to label things in his environment). Each child has their own method of communication – words, signs, augmentative devices, pictures but all people deserve to be effective communicators. All skills are examined comprehensively to see if they are emerging evenly across all areas of language.

Most traditional language approaches differentiate between receptive (listener skills) and expressive (vocal) language. Skinner's functional analysis of verbal behavior further analyzes vocal behavior according to its function. Mand (request), tact (label) and intraverbal (talking about things in the absence of those things) are all components of "expressive language." Focusing on the reasons we say words rather than the form of the response allows us to teach functional language skills more effectively to learners with language difficulties.

The Verbal Operants:

- **Mand** = **request** (you say it because you want it)
- **Tact** = **label** (you say it because you see, hear, smell, taste, or feel something)
- **Intraverbal** = **conversation, answering a question, responding when someone else talks (**you say it because someone else asked you a question, or made a comment)
- **Echoic** = **repeating what someone else says** (you say it because someone else said it)
- **Imitation** = **repeating someone else's motor movements** (you move because someone else moved the same way)
- **Listener Responding/Receptive** = **following directions** (you do what someone else asks you to do)

*Our goal is to help our clients understand that communicating produces positive results in their immediate environment.

Assessments: [VB-MAPP, FBA, ABLLS-R, AFLS, etc.]

(VB-MAPP) - The **Verbal Behavior Milestones Assessment and Placement Program** is a developmentally based criterion referenced assessment tool that was field-tested with typically developing children and children with ASD. The VB-MAPP assesses individual skills within each repertoire area, such as the echoic, mand, tact, intraverbal, etc. It also assesses the child's barriers to learning and contains a transition assessment which is to aid providers in making placement decisions about the level of inclusion or group instruction that may be appropriate for that learner. There are five components of the VB-MAPP (Milestones Assessment, Barriers Assessment, Transition Assessment, Task Analysis and Supporting Skills, and Placement and IEP Goals), and collectively they provide a baseline level of performance, a direction for intervention, a system for tracking skill acquisition, a tool for outcome measures and other language research projects, and a framework for curriculum planning. Each of the skills in the VB-MAPP is not only measurable and developmentally balanced, but they are balanced across the verbal operants and other related skills.

(FBA) - A **Functional Behavior Assessment** is the primary tool used to identify and attempt to understand a child's behavior. It is a multidisciplinary approach that incorporates a number of techniques, sources of information, and strategies to understand the reasons behind problem behavior and to develop strategies or interventions to address the problem behaviors. The process involves documenting the antecedent(s) (what comes before the behavior), the behavior of concern, and the consequence(s) (what happens after the behavior) across time. Practitioners interview teachers, parents, and others who work with the child. Practitioners may manipulate the environment to see if a way can be found to prevent the behavior. This information is important because it leads the observer beyond the "symptom" (the behavior of concern) to the student's underlying motivation to "escape", "avoid," or "get" something, which is the root to all behavior. The findings from the FBA become the basis for the Behavior Intervention Plan (BIP).

(ABLLS-R) - The **Assessment of Basic Language and Learning Skills** - **Revised** is an assessment tool, curriculum guide, and skills-tracking system used to help guide the instruction of language and critical learner skills for children with autism or other developmental disabilities. The ABLLS-R contains a task analysis of the many skills necessary to communicate successfully and to learn from everyday experiences. It provides both parents and professionals with criterion-referenced information regarding a child's current skills and provides a curriculum that can serve as a basis for the selection of educational objectives.

(AFLS) - The **Assessment of Functional Living Skills** is an assessment, skills tracking system, & curriculum guide for the development of essential skills for achieving independence. It can be used to demonstrate a learner's current functional skill repertoire & provide tracking info for the progressive development of these skills. The AFLS contains task analyses of the skills essential for participation in family, community, & work environments.

Other assessments are completed based on the individual needs of each child.

Behavior Intervention Plans (BIPs)

Behavior Intervention Plans (BIPs) are developed from a Functional Behavior Assessment (FBA). BIPs increase the acquisition and use of new alternative skills, decrease the problem behavior and facilitate general improvements in the quality of life of the individual, his or her family, and members of the support team.

Social Skills Training

We provide social skills training to children with autism spectrum disorder and other developmental disabilities. The focus of the program is to increase the child's overall ability to do the following:

- Recognize and interpret verbal and non-verbal communication
- Develop appropriate peer relationships
- Improve social interactions by expanding interest in age-appropriate topics, toys and play skills
- Increase their ability to recognize others' emotions
- Participate in social interactions with minimal stress and anxiety
- Learn to use tools necessary for successful interpretation of social and communication skills

Functional Communication Training (FCT)

FCT is used to teach and establish replacement behaviors for inappropriate or potentially harmful behaviors such as aggression, escape/elopement, non-compliance, and other challenging behaviors. When a child is regularly engaging in disruptive behavior, the child is likely having difficulty communicating or meeting their wants and needs. It is our role to develop a comprehensive ABA program to replace challenging behaviors with more effective and efficient positive/functional behaviors to get their needs and wants met in a more socially acceptable manner.

Professional Development Training (Parent/Tutor/Teacher)

Our team offers a wide range of professional development training for parents, families, and school districts in Applied Behavior Analysis. Our workshops / training are available in full day sessions, half day sessions and evening sessions. Workshops and training can be tailored to meet your individualized needs for professional development. Please contact us for more information.

School Consulting

Our team offers consultation for individuals in their public and private school settings and also contracts with schools who are seeking ABA services or consultation. Community School can provide services which address needs such as assessments, behavioral assessments, teacher and staff training, modification of curriculum, social skills facilitation, program development, and ongoing supervision.

IEP Development and Support

For learners enrolled in public school, private school, or another educational institution, our behavior analysts can provide on-going collaboration throughout the Individualized Education Plan (IEP) process, including the construction of IEP goals and objectives, assisting in the implementation of the goals in the home and school settings, and reporting of progress.

- Each learner enrolled in Community School has an individualized treatment plan developed by Community School BCBA(s) / BCaBA(s) based on the historical information provided by parents / guardians, direct observation of learner skill sets (strengths & deficits) & behavioral excesses, and parent priorities.
- Community School is NOT required or obligated to follow IEPs or IFSPs developed by public school providers prior to starting at Community School.

Orientation to Services

What does treatment look like?

Treatment is viewed as a team process between the supervisors (BCBA & BCaBA), instructors (behavior technicians), family members (parents, grandparents, siblings, etc.), other caretakers / service providers (occupational therapist, physical therapist, speech/language pathologist, home-school staff, respite workers, babysitters, etc.), and others as deemed appropriate. Feedback regarding progress is welcomed at any time. Change will often occur as a result of the hard work of the client and family members. There will often be assignments between home visits.

When can I expect home visits?

Visits are scheduled directly with the learner and/or family. Each visit generally lasts 2-4 hours. The format can be individual, family, or a combination depending on the presented issues. The number of sessions per week/day will depend upon the learner's treatment hour recommendation.

How are appointments scheduled?

Appointments are scheduled in advance following collaboration with the family. If an appointment is canceled due to a conflict less than 24 hours before a scheduled appointment, the client or parent is responsible for contacting the supervisor or designated scheduling coordinator to inform them and reschedule.

How are missed appointments handled?

If a client or parent does not give 24 hours' notice for canceling or missing an appointment, a fee may be charged equivalent to the allowed fees by the third-party payer. The BCBA has the discretion to waive this fee if extenuating circumstances prevented the client from keeping the appointment. If the client canceled or missed three appointments, the need for services will be reviewed and a determination made as to whether to terminate the case.

Treatment Planning:

Maladaptive behaviors and communication deficits determine the direction of ABA treatment. The BCBA/BCaBA, client, and family members, as appropriate, select specific goals and review progress towards goals on a regular basis. Changes or modifications to the treatment plan may be made at any time; however, changes must receive approval from the BCBA and parents prior to implementation. BCBA approval shall depend upon conformity to industry standards, insurance limitations, professional ethics, and the BCBA's/BCaBA's best judgment as to how the change(s) may support and/or fit together with the rest of the plan. (Technicians take direction exclusively from the BCBA/BCaBA and have no authority to modify treatment plans.)

What occurs upon the completion of treatment:

Treatment is completed when the client and family members, along with the BCBA/BCaBA, consider significant progress towards agreed-upon goals has been met, and in addition, no new issues or problems have emerged. Discharge criteria will be discussed in advance; titration of treatment hours is common when such progress has been made.

Policy on Confidentiality:

All information shared is confidential. Nothing can be released without the written consent of the client or the client's legal guardian; however, if the client is judged to be imminently suicidal or homicidal, then Louisiana state law allows for breach of confidentiality. If child abuse or adult abuse is reported to the BCBA/BCaBA, Louisiana State law mandates that the abuse be reported to the Department of Social Services. Other exceptions are outlined in the Human Rights Policy. If a parent/caretaker brings a child or adolescent in for treatment, a verbal or written agreement will be established at the start of treatment regarding what is shared with the parent/caretaker.

Program Description

Program Description

We provide direct center-based, home-based, school-based, and community-based services to children, adolescents, and their families. Services are appropriate for families who have one or more children who fall on the autism spectrum or have been diagnosed with other developmental disabilities. These services are provided without regard to race, religion, national origin, sex or cultural differences. The primary goal of this program is to preserve the family unit and improve quality of life for the learner or client and their family. Treatment services are aimed at developing and improving the learner's communications skills, increasing social interactions with others, and expressing and coping with emotions while developing self-regulation strategies.

This program is committed to providing effective support to families through flexible, timely and least intrusive services. "Least intrusive services" is defined as planning and providing services based upon ongoing family needs and using the appropriate quantity of services as required. Our core principles inform our practices and include the following:

1. The provision of "Applied Behavior Analysis" as defined in state law and by the Behavior Analyst Certification Board (BACB).
2. Services are built around family preferences, choices, values, individual strengths, and include the person's family and community support system as much as possible.
3. Families are the primary decision-makers for their child and family.
4. Services are based on culture- and age-appropriateness and are aimed at maximizing interagency cooperation to maintain the youth in the family or community.

Client Rights and Responsibilities

Although these rights are written for the client, in most cases they also apply to the client's parents or legal guardians. We expect staff, clients, families and visitors to act in a reasonable and responsible way at all times. If you have a concern about any of these rights or responsibilities, please address your concerns first with your immediate supervisor and/or clinical supervisor to discuss concerns / solutions. Staff and/or other individual(s) involved will be notified as needed.

Client Rights

You Have the Right…

…to considerate, respectful care at all times and under all circumstances with recognition of personal dignity
…to personal and informational privacy (within the law)
…to verbal and written communications regarding learner progress / continued care
…to verbal and written communications regarding changes to policies and procedures
…to participate in the development and evaluation of the services provided to your child
…to expect that our staff is competent to obtain and interpret information in terms of your needs and to have an understanding of the range of treatment needed
…to assistance with conflicts regarding services rendered
…to file a complaint or grievance with the Louisiana Behavior Analyst Board or the Behavior Analyst Certification Board
…to have written and electronic records kept confidential, except for disclosure as required by law
…to access records about your child in accordance with applicable state and federal law, regulation, or rule
…to refuse or terminate services and be informed of the consequences of refusing or terminating services
…to a coordinated transfer to ensure continuity of care when there will be a change in provider

You Have the Responsibility…

…to be courteous to other clients and staff
…to be on time for all appointments and cancel 24 hours in advance
…to respect the rights of others including their confidentiality
…to discuss *(as appropriate)* your own / your family's / learner's symptoms and problems as honestly and as completely as possible *(e.g., past illnesses, hospitalizations, medications and other matters relating to your child's health.)*
…to follow treatment plans recommended by the Community School clinicians
…to participate fully in the parent-training component of your child's treatment program
…to ask questions about any aspect of the treatment plan that you do not agree with or understand
…to understand all documents that you place your signature on for approval or agreement
…to accept responsibility for your actions if you refuse treatment or do not follow the practitioner's instructions
…to assure that the financial obligations of your learner's health care/service are fulfilled as promptly as possible
…to inform Community School of any changes in your personal situation such as, address, phone numbers, insurance information

Failure to notify supervisor of insurance changes may result in abrupt discontinuation of services for insurance to make changes to the authorization of services currently in place.

Our staff is dedicated to helping children with diverse learning abilities learn skills to successfully navigate the different areas of life in all the places that life happens. Throughout the treatment process our staff strive to protect the dignity and welfare of all who receive services from us.

Our Ethical Obligations:

1. Serving the best interest of each client
2. Not discriminate between clients or professionals based on age, race, creed, disability, handicap, preference, or other personal concerns.
3. Maintain an objective and professional relationship with each client.
4. Respect the rights and views of other mental health professionals.
5. Appropriately end services or refer clients to other programs when appropriate.
6. Evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement
7. Continually attain further education and training
8. Respect various institutional and managerial policies but help to improve such policies if the best interest of the client is not being served.

What to do if you believe your rights have been violated:

If you believe that your client rights have been violated, contact our Program Director immediately for resolution.

How to Get Help During an Emergency

If this is a **medical emergency, dial 911**, and follow the operator's instructions.

For access to **Poison Control, call 1(800) 222-1222**.

If you would like to contact your BCBA/BCaBA for an emergency, please call the Community School phone immediately **318-401-4959**

Consent for Treatment and Recipient's Rights

Client Name: _____ DOB: _____

I, _____ the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, hereby referred to as Community School. Further, I consent to have treatment provided by the BCBA, BCaBA, and the Technician(s) on the case. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages this decision be discussed with the treating BCBA. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received information concerning Recipient's Rights and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor. Unless otherwise notified, I understand that my Recipient's Rights Advisor is the BCBA overseeing my case.

Non-voluntary Discharge from Treatment: A client (i.e., "*client*" refers to the client and their family) may be terminated non-voluntarily if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts; and/or (B) the client refuses to comply with stipulated program rules or refuses to comply with treatment recommendations. The client will be notified of a non-voluntary discharge by letter. The client may appeal this decision with the Clinical Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of client records maintained is protected by federal and/or state law and regulations. Generally, we may not say to a person outside of Community School that a client attends the program or disclose any information identifying a client unless: (1) the client consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation/implementation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a client either at Community School, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is Community School's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Client/Legal Guardian's Initials _____

Professional misconduct by a healthcare professional must be reported by other health care professionals, in which case related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, but not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation/coordination and child advocacy purposes, but individual results will not be disclosed to outside persons not related to the child's care.

I consent to treatment and agree to abide by the above-stated policies and agreements with Community School.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

**In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf.*

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of Community School.

I hereby authorize Community School to: (check all that apply)

____ Exchange information with

____ Release information to

____ Obtain information from

The following Organization/Individual in regard to the above-named client:

Name of Organization/Individual: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):

____ Verbal only

____ Written form only

____ Both verbal and written communication

Description of information to be exchanged / released / obtained: (select all that apply)

____ Education records

____ Evaluation/assessment/eligibility records

____ Medical records

____ Clinical records (including behavior analytic, psychological, physical, occupational, & speech therapies)

____ Other: _____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain in effect for 1 year, unless otherwise stipulated or revoked in writing.

Community School _____(MM/DD/YYYY) to _____MM/DD/YYYY)

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Authorization to Bill Insurance

Client Name: _____ DOB: _____

I, _____, hereby give my consent for Community School to bill my/my child's insurance carrier for the services rendered to my child by the above- mentioned provider. In addition, I agree to pay Community School, any deductible or uncovered charge in accordance with my health care plan.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Human Rights Notification

Each individual who receives services shall be assured protection to exercise his/her legal, civil and human rights related to the receipt of services, shown respect for his/her basic dignity, and provided services consistent with sound therapeutic practices.

Every client receiving services will be treated with dignity and be protected, respected, and supported in exercising all of his/her legal, civil and human rights. All staff are prohibited from limiting or taking away these rights for any reason, including a client's disabilities or barriers that may be created due to a disability.

It is your right…

… to be treated with dignity and respect
… to ask questions and be told about your treatment
… to have a say in your treatment
… to speak to others in private
… to have complaints resolved
… to say what you prefer
… to ask questions and be told about your rights
… to get help with your rights

Upon request you will be given a complete copy of the Human Rights Plan and/or a copy of the Louisiana State Human Rights Regulations.

_____(Initial) No, I would NOT like to request a complete copy of the Human Rights Plan or the Louisiana State Human Rights regulations.

_____(Initial) Yes, I would like to request a complete copy of the Human Rights Plan and the Louisiana State Human Rights regulations.
Date of copy given to client/parents ____/____/_____

Clients must be notified in writing annually of his/her human rights.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Client Grievance Procedures

When a client or parent has a grievance with a behavior technician, they should address the matter directly with the technician's supervisor (BCBA/BCaBA). If the matter is not resolved within a reasonable period of time, the client or parent should address the issue a second time with the technician's supervisor.

If the concern remains unsettled, then the client or parent should make an appeal to the Program Director. The Program Director shall have power to make final determinations on all clinical decisions related to services provided by Community School, which fall under her oversight. If the complaint involves a problem which goes beyond clinical care, or involves the Program Director herself, then the client or parent may request to be referred and transitioned to another practicing licensed behavior analyst for services.

When a client has a grievance with an administrative staff, they will be directed to address the grievance with their BCBA/BCaBA first. If the grievance cannot be resolved with the BCBA/BCaBA, the Program Director will be called upon to address the grievance. The Program Director has the authority to make final administrative decisions on behalf of Community School.

Anytime there is a grievance made about an administrative staff, technician, or BCaBA/BCBA, that person will be informed of the grievance and be given an opportunity to participate in the resolution of the grievance as appropriate. All parties agree to act in good faith to resolve grievances in the simplest and most respectful manner possible. A client or parent always has the right to discontinue services at any time.

Certification & Licensure Board Information

Licensed Behavior Analysts (LBAs) and State Certified Assistant Behavior Analysts (SCABAs) are licensed and certified by the Louisiana Behavior Analyst Board (LBAB). Registered Line Technicians (RLTs) and SCABAs practice under the direct supervision of the LBA. More information can be found at www.lababoard.org. Complaints can be made on this website.

To become licensed on the state level, behavior analysts must first be nationally certified by the Behavior Analyst Certification Board (BACB). Board Certified Behavior Analysts (BCBAs) and Board Certified Assistant Behavior Analysts (BCaBAs) are nationally certified by the BACB. More information can be found at www.bacb.com. Complaints can be made here as well.

All certifications and licenses can be made available for review upon request.

How to Contact your Service Providers

ABA services will be provided Monday through Friday from 8:00am to 4:00pm weekly. Saturday/Sunday sessions are also offered most weekends from 9:00am to 12:00pm; weekend sessions are optional and scheduled by parent request. Emergency services will be available 24 hours a day, 7 days a week.

***For routine communication** (*scheduling changes, canceling appointments, etc.*) **contact the Community School cell phone and leave a message (318) 401-4959**

***For communication regarding clinical concerns and updates** (*medication updates, concerning changes in learner behavior in other settings, etc.*) **contact one of your clinical supervisors** (**see contact info below*)

For questions and concerns that require any back-&-forth discussion, caregiver training meetings may need to be scheduled – *these meetings can be conducted in-person (on-campus; client's home) or via Zoom.*

Clinical Supervising Staff

Director:	**Kelly Rouse**	**Email:**	**krouse@communityschool-shreve.com**
Supervisor:	**Elizabeth Murray**	**Email:**	**emurray@communityschool-shreve.com**
Supervisor:	**Chynna Coleman**	**Email:**	**ccoleman@communityschool-shreve.com**
Supervisor:	**Whittney Plunkett**	**Email:**	**wplunkett@communityschool-shreve.com**
Supervisor:	**Nikki Abrams-Bracey**	**Email:**	**lbracey@communityschool-shreve.com**

Contacting Your Service Provider

While they are usually available, they will not answer the phone if they are with a client. When they are unavailable, please leave a message on their voicemail or by text. They will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform them of some times when you will be available.

If you are unable to reach them and feel that you cannot wait for them to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your service provider is unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary.

Email is not a secure, confidential form of communication and should therefore not be used for communication related to private information. **FAX #: 318-416-9604**

Privacy of Information Policies

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties

State and federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any policy changes will be made available in writing, upon request, prior to their effective date. The contents of material disclosed to us in an evaluation, intake, or therapy session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with Community School, for diagnosis, treatment planning, treatment, advocacy, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, other health professionals, mental health professionals/students, or to business associates affiliated with ABA such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this practice not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the healthcare professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If child abuse or adult abuse is suspected by or reported to the BCBA/BCaBA, Louisiana State law mandates that the abuse be reported to the Department of Social Services, even if they must reveal some information about a client's treatment. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a healthcare professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been issued. In most legal proceedings, you have the right to prevent your BCBA/BCaBA from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your BCBA's/BCaBA's testimony if he or she determines that the issues demand it.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. Records are made available upon request in a timely manner. The BCBA has 30 business days to supply all records as requested.

Other Provisions

When payment for services is the responsibility of the client, or when a person who has agreed to provide payment, has not made payment in a timely manner, collection agencies may be utilized in collecting unpaid debts. In such a case, specific content of services (e.g., diagnoses, treatment plans, progress notes, testing) is not disclosed. If a debt remains unpaid, it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnoses, treatment plans, description of impairment, progress of therapy, graphs, and summaries.

Information about clients may be disclosed in consultations with other professionals to provide the best possible treatment. In such cases, client names and identifying information are not disclosed.

In the event in which the healthcare professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you on cell, at home, or work, we do not say the name of the practice or the nature of the call, but rather the healthcare professional's first name only. If this information is not provided to us, we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voicemail, we will follow the same guidelines.

Special Education Advocacy

In the event we provide special education advocacy services, most references to the client's medical condition will be contained within the record available to the appropriate school personnel and IEP team and therefore will not require additional disclosure. However, there may be incidental references to pertinent information not contained within the record, particularly when relaying observations made by Community School's personnel which might be strategically important to address on the client's behalf. Our staff is authorized to communicate with school personnel within the scope of advocacy services on behalf of the client and guardian. Community School's staff shall promptly make known to the client/guardian the substance of such communications.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information are as follows: You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians.

You have the right to cancel a release of information by providing a written notice. If you desire to have your information sent to a location different from our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice, you may obtain it by requesting it from the Program Director.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Confidentiality Act - Abuse-Reporting Protocol

Client Name: _____ **DOB: _____**

I understand all information related to the above-named client's assessment and treatment must be handled with strict confidentiality. No information related to the client, either verbal or written, will be released to other agencies or individuals without the express written consent of the client's legal guardian. By law, the rules of confidentiality do not hold under the following conditions:

1. If abuse or neglect of a minor, disabled, or elderly person is reported or suspected, the professional involved is required to report it to the Department of Children and Families for investigation.

2. If, during the course of services, the professional involved receives information that someone's life is in danger, that professional has a duty to warn the potential victim.

3. If our records, our subcontractor records or staff testimony are subpoenaed by court order, we are required to produce requested information or appear in court to answer questions regarding the client.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Freedom of Choice of Provider

I understand I have a choice of providers for receiving ABA home-based, school-based, or community-based services. I have been made aware that I have a choice of other providers offering this service and have chosen Community School as my service provider.

RIGHT TO APPEAL

I also understand that if I have any concerns about decisions that affect my receiving this service, I have the right to appeal. Upon request, Community School will supply me with all information necessary in accessing my right to a fair hearing.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Functional Behavioral Assessment (FBA) Consent Form

As a way to best serve your child, _____, we would like to conduct a Functional Behavioral Assessment (FBA). A Functional Behavioral Assessment is the process of:

- Identifying problematic behavior(s)
- Identifying environmental events which impact problematic behavior(s)
- Determining the cause/function of the problematic behavior(s)
- Outlining strategies/interventions that may be effective based on data collected during the FBA process

An FBA may include, but is not limited to, the components:

- REVIEW OF RECORDS: Including medical records; progress notes / evaluations from other therapy service providers (OT, PT, SLP, etc.); history of problematic behavior(s) and previous interventions (time implemented; effectiveness; etc.)
- INTERVIEWS / RATING SCALES: Completed by the learner (if applicable), parent(s) / guardian(s), caretaker(s), teacher(s) regarding the learner's behavior
- DIRECT OBSERVATION: Conducted across settings/situations in which learner does / does not engage in problematic behavior(s)
- DATA COLLECTION: Objectively define problematic behaviors, what happens right BEFORE problematic behavior(s) occur (Antecedents) and what happens right AFTER problematic behavior(s) occur (Consequences) and measure current levels of problematic behavior(s) (e.g., frequency; rate; duration; etc.)

We greatly appreciate your involvement during each step of the process. The assessments will be shared with you upon completion. Please sign below to indicate whether or not you give consent for Community School to conduct a Functional Behavior Assessment (FBA) for problematic behavior(s) identified below and to also continue to collect information throughout the 6-month authorization period for tracking, updating and modifying purposes. Please initial next to each problematic behavior listed. A new FBA Consent Form will be completed for any new problematic behaviors that arise not listed on the current consent authorization form.

☐ I DO give consent for my child, _____, to participate in a Functional Behavioral Assessment for the problematic behavior(s) initialed below.

☐ I DO NOT give consent for my child, _____, to participate in a Functional Behavioral Assessment for the problematic behavior(s) initialed below.

_____(Initial) (Behavior 1) _____

_____(Initial) (Behavior 2) _____

_____(Initial) (Behavior 3) _____

_____(Initial) (Behavior 4) _____

_____(Initial) (Behavior 5) _____

_____(Initial) (Behavior 6) _____

_____(Initial) (Behavior 7) _____

_____(Initial) (Behavior 8) _____

***Write in all behaviors of concern, each on a separate line. Initial next to all behaviors listed.**

- Property destruction
- Self-Injurious Behavior
- Social Intrusion
- Air gulping
- Disrobing
- Disruptive Behavior
- Tantrums
- Aggression
- Stereotypy
- Noncompliance
- Pica
- Elopement
- Any Other Behaviors of Excess (*i.e., any behavior that happens TOO MUCH)*

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Permission to Photograph/Videotape/Audiotape

Client Name: _____ DOB: _____

_____ I give permission and consent for Community School to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations and/or to document progress. I understand that this is a voluntary agreement and will not affect my child's therapy program and can be changed at any time.

_____ In addition to the above, I also give permission for Community School to use full-face photographs of my child for promotional or marketing materials, including digital platforms such as social media and Community School website.

_____ I give permission and consent for Community School to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the tapes will be used for the purposes of developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Community School.

___ I DO NOT give permission for Community School to take photographs of my child. I understand that this is a voluntary agreement and will not affect my child's therapy program and can be changed at any time.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Consent for Participation in Swim Program

Client Name: _____ DOB: _____

Children enrolled in Community School will be scheduled for classroom group swim instruction as part of their physical education throughout the year.

WHEN:

- Swim classes will be occur 2-3 times per week

WHERE:

- Swim classes will occur a the YMCA

WHO:

- Swim classes will consist of the same peers from the regular classroom
- Classes will be conducted by a minimum of 2 staff members:
  - Lead instructor (in water) – *focus on water safety & swim instruction*
  - Assistant(s) (on deck) – *focus on behavior (i.e., implement BIPs-- antecedent & consequence procedurces).*
- All swim classes will occur under lifeguard supervision

WHAT:

- Swim program areas of focus include….daily physical activity; compliance; following instructions; safe/age-appropriate leisure activities in water; stroke/motor skill development; communication/language

HOW:

- Class swim programs will be…individualized to the needs & skill level of class; conducted using strategies based on the principles of behavior; sdeveloped & overseen by supervising BCBA/BCaBA

Please initial your preference in the box.

☐ I give my child permission to participate in the Community School swim program conducted at the YMCA – (BHP Location off Clyde Fant Pkwy).

☐ I DO NOT give my child permission to participate in the Community School swim program.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Telehealth Practices & Protocols

During COVID19, the use of Telehealth services was critical to the management of patient care, preventing interruptions in treatment delivery when possible. Telehealth proved, in many cases, to be beneficial as an additional component to ABA treatment package, particularly for caregiver collaboration and training. Telehealth activities include the following:

- Real-time, videoconferencing visits
- Parent training, education, or collaboration
- Delivery of therapeutic services by a trained Registered Line Tech (RLT), Board-Certified assistant Behavior Analyst (BCaBA), or Board-Certified Behavior Analyst (BCBA) as deemed appropriate
- Remote patient monitoring procedures for those in rural areas lacking direct care services

The goal of telehealth is not to replace direct care of patients but instead increase the overall health and generate positive impact for clients and their families. Parent training and supervision may also occur via Telehealth in cases where direct supervision is not possible due to distance of travel or other unforeseen circumstances.

Consent for Telehealth Services

1. I understand that my health care provider wishes me to engage in a telehealth session to receive behavioral health services appropriate for my treatment plan.
2. I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
3. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this protocol. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Consent to Use the Telehealth by Zoom Service

Telehealth by ZOOM is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Zoom is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Telehealth by Zoom Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
3. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Zoom Service – or that such information is current, accurate or up to date. I will not rely on my health care provider to have any of this information in the Telehealth by Zoom Service.
4. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING THIS FORM, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Informed Consent for Restrictive Procedures

This document is to inform parents of Community School's general clinical emergency / crisis plan for any situation in which a client poses serious risk of harm to self or others. In the case of a crisis or clinical emergency, Community School staff are trained to immediately contact both their supervisor and additional specialized staff certified in Professional Crisis Management (PCM). At least two adults stay with a client in crisis, at all times. The "2 to 1 Rule" allows for one staff member to focus solely on implementing de-escalation procedures and the other to ensure and maintain a safe environment and gather materials, as needed, to ensure efficiency of intervention implementation and de-escalation strategies. All efforts are taken to minimize the risk of physical harm to client and others while implementing de-escalation and crisis management strategies.

PCM Crisis Strategies including Transports and Immobilization shall only be implemented with clients by staff members certified in PCM.

PCM Crisis Strategies and number of utilized Strategies used during a client's behavioral episode shall be documented.

Community School staff receive PCM training In-house as the Director is a certified PCM trainer. If interested and pass physical pre-requisites, parents / caregivers are welcome to complete the training when course spots are available.

- [*Self-Harm*] – If a client is placing himself/ herself in a situation where he/she may get seriously hurt, trained staff will act to prevent learner from harming self. Situations where a client may place themselves in harm's way may include, but are not limited to, running from building or into rooms where there are dangerous items with which the client might use to climb to dangerous heights, use for significant self-injurious behaviors, etc. A client may also be deemed at risk of harming himself/herself if engaging in self-injurious behaviors such as excessive head banging, biting self, scratching self, excessive hair pulling, etc.
- [*Harm to Others*] - If a client attempts to harm others including staff or other clients, trained staff will act to prevent the child from harming others. Situations where a client may place others in harm's way may include, but are not limited to, hitting, kicking, biting, using objects to harm others, or threatening others and a history of following through on such threats, etc.
- [*Property Destruction*] - If a client is destroying property, verbal and non-verbal techniques are therapists' first choices when responding to the behavior. The only time Transports and Immobilization would be used is when the destruction of that property places the client at-risk of self-harm and using the destroyed items to harm someone else. For example, if a client is attempting to break glass, this would be a time to intervene as serious injury may result from broken glass.
- [*Elopement*] - If a child runs away or bolts, ABA approaches such as Blocking and Redirection using physical prompts to return the child to the expected area will be used. However, if a client is highly dysregulated, at risk of running outside building or to access open area, placing them at risk of being harmed by traffic or other situations, then Transports and Immobilization would be implemented to reduce the risk of harm by potentially life-threatening safety concerns posed by level of traffic and other safety concerns present in immediate vicinity outside the building or designated area.

Parents will be informed if this intervention has been required. If a pattern begins to emerge of a learner needing intervention by PCM trained staff, a meeting will be held with parents to review treatment plan and intervention changes / modifications to make to interrupt emerging pattern and intervene more proactively (e.g., antecedent manipulations to reduce likelihood; reinforce precursor behavior(s), etc.).

BY SIGNING THIS FORM, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Health Insurance Portability and Accountability Act Privacy Notice (HIPAA)

This notice describes how Community School uses and discloses your medical and other identifying Protected Health Information (PHI). In addition, this notice describes your legal rights regarding your records and the process for accessing your records. Please review this notice carefully.

You will be asked to sign the Authorization for Treatment Form, later in this packet, to document your receipt of this information and formal agreement of these practices.

As part of providing services, Community School will collect PHI about your child's health care and your family. Community School needs this PHI to provide quality services and to comply with certain legal requirements. This notice applies to all records generated by Community School. This law requires us to:

- Make sure that records with identifying PHI are kept private
- Give you this notice of our legal duties and privacy practices with respect to PHI
- Follow the terms of the Privacy Notice that is currently in effect

How Community School May Use and Disclose PHI

Listed below are a number of reasons or ways in which Community School may disclose PHI. In each category, there is an explanation of the reason and usually an example. This notice DOES NOT LIST EVERY USE OR DISCLOSURE IN A CATEGORY. **The reasons Community School might disclose PHI includes:**

- **For Treatment:** Community School may disclose PHI to Community School personnel or outside of Community School to others who are involved in providing care to you or your child. For example, Community School staff have weekly small team meetings with the clinical supervisor and other therapists on team to discuss challenging behaviors and programming and may share PHI at that time. In addition, with written consent, Community School may communicate with your child's Parish Case Manager.

- **For Payment:** Community School may use and disclose PHI so that services can be billed and payment can be collected from an insurance company or government health program. Community School may also tell your health plan provider about a service your child may receive to obtain prior approval or to determine whether your health plan will cover the recommended treatment services. As legal guardians, you must provide informed consent for Community School to release this PHI.

- **For Health Care Operations:** Community School may use PHI to maintain quality programs, to make sure Community School is providing quality services, or to decide if services should be changed or modified.

- **As Required by Law:** Community School will disclose PHI when required by federal, state, or local law. For example, state law requires Community School to report suspected abuse or neglect to the proper authorities, which will require the release of PHI. This use of PHI does not require consent.

- **To Avoid a Serious Threat to Health or Safety:** Community School may use or disclose PHI when necessary to prevent a serious threat to your child's health and safety or the health and safety of the public or another person. As legal guardians, you will have the opportunity to provide written consent for this use of PHI.

- **Military and Veterans:** If you are a member of the armed forces, Community School may release PHI about you as required by military command authorities without additional consent.

- **Workers' Compensation:** Community School may release PHI for workers' compensation or similar programs when required by law to do so. For example, if you are involved in a claim for workers' compensation benefits, Community School may release PHI requested about your child's health.

- **Health Oversight Activities:** Community School may disclose PHI to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections, and licensure.

- **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning our services or someone who provided services to you, Community School may disclose PHI in response to a court or administrative order. Community School may also disclose PHI in response to a subpoena, discovery request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to inform you about the request prior to providing the PHI to allow you to obtain an order protecting the PHI requested.

- **Law Enforcement:** In certain situations, Community School may release PHI to law enforcement officials. For example, Community School might release PHI to identify or locate a missing person; report a death at Community School that may be the result of criminal conduct; or report a crime in emergency circumstances.

- **Coroners, Medical Examiners and Funeral Directors:** Community School may release PHI to a coroner or medical examiner to identify a deceased person or determine a cause of death. Community School may release PHI to funeral directors as necessary to help them carry out their duties.

- **National Security and Intelligence Services, Protective Services for the President, and Others:** Community School may release PHI to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

- **Correctional Programs:** If you are an inmate or in the custody of a law enforcement officer, Community School may release PHI to the correctional institution or law enforcement official, to protect your health and safety or the health and safety of others.

Your Rights and Your Child's Rights Regarding Your Protected Health Information

As legal guardians for your child, you have the following rights:

1. **To Inspect and Copy Community School Service Records:** Usually this includes medical and billing records but may exclude session notes. To inspect and copy PHI in your record you must submit a request in writing to the HIPAA Compliance Officer / Business Manager. Community School is allowed to charge a reasonable fee for the costs of copying, mailing, or other costs related to your request.
   In very limited circumstances Community School may deny your request. If Community School denies your request, you may ask that the denial be reviewed. Another licensed health care professional of Community School will then review your request and either uphold the original decision or reverse it.

2. **To Amend Your Records:** If you believe that the PHI Community School has about you and/or your child is incorrect or incomplete; you may make a written request to the HIPAA Compliance Officer / Business Manager to amend the PHI. You must include a reason that supports your request.

   Community School may deny the request if it is not in writing or does not include reasons to support the request.

   Community School may also deny your request if you ask us to amend PHI that:

   - was not created by us, unless the person/entity that created the PHI is no longer available to make the amendment
   - is not part of the PHI kept in our file
   - is not part of the PHI you would be permitted to inspect and copy
   - Community School believes the PHI is accurate and complete

If you disagree with the denial, you may submit a statement of disagreement. If you request an amendment to your record, Community School will include your request in the record, whether the amendment is accepted or not.

3. **To Receive an Accounting of Disclosures:** Community School will keep a log of disclosures made on or after October 06, 2025, other than disclosures for treatment, billing, or health care operations. You have the right to request the list of disclosures. You must submit a written request to the HIPAA Compliance Officer / Business Manager. The request may not cover more than a six-year period.

4. **To Request Restrictions:** You may request a restriction on the disclosure of PHI for treatment, payment, or health care operations. Your request must be in writing to the HIPAA Compliance Officer / Business Manager.

   Your request must clearly state:

   1. What PHI is to be limited
   2. Whether you want to limit our use, our disclosure or both
   3. To whom you want the limit to apply. For example, you could ask that Community School not use or disclose PHI to a certain person about services your child has received.

   Community School DOES NOT have to agree to your request to restrict access to PHI.

   If Community School DOES agree, Community School will comply with your request unless the PHI is needed to provide emergency treatment or to comply with a lawful and legal request or investigation.

5. **To Request Alternative Ways to Communicate:** You may request that Community School communicate with you about services in a certain way or at a certain location. For example, you can ask that Community School contact you only at work, or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and must be sent to the HIPAA Compliance Officer / Business Manager. Community School will accommodate all reasonable requests.

6. **To Receive a Paper Copy or Electronic Copy of this Notice:** You have the right to receive a paper or an electronic copy of this notice from the HIPAA Compliance Officer / Business Manager.

Additional Rights Under State Law: State privacy laws may provide additional privacy protections. Any such protections will be attached in a separate State addendum to this Notice.

Changes to this Notice: Community School may change this notice in the future. Community School can make the revised or changed notice effect for PHI Community School already have about you as well as any PHI Community School may create or receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer / Business Manager or with the Secretary of Health and Human Services. All complaints must be in writing. Community School will not retaliate against you for filing a complaint.

BY SIGNING THIS FORM, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature of Parent/Guardian: _____ Date:_____/_____/____

Signature of Client (if applicable): _____ Date:_____/_____/____

Participating Staff Signature: _____ Date:_____/_____/_____

Community School

TUITION AGREEMENT 2026-2027

_____

STUDENT NAME

_____

CAREGIVER'S/GUARDIAN'S NAME

_____

CAREGIVER'S/GUARDIAN'S EMAIL

_____

RESPONSIBLE PARTY NAME

RESPONSIBLE PARTY MAILING ADDRESS:

_____

_____

_____

_____

ADDITIONAL RESPONSIBLE PARTY NAME (IF APPLICABLE)

_____

RESPONSIBLE PARTY PHONE

_____

RESPONSIBLE PARTY EMAIL

Community School

TUITION PAYMENT OPTIONS

_____ LUMP SUM PAYMENT OF $8000 DUE BY 9/30/26

_____ SEMI-ANNUAL PAYMENTS (2) OF $4000 EACH. FIRST PAYMENT DUE BY 09/30/26 AND THE SECOND IS DUE 02/28/26

_____ 12 MONTH AUTOMATIC PAYMENT OF $665.00 PER MONTH. PAYMENT IS DUE ON THE LAST DAY OF THE MONTH.

METHOD OF PAYMENT

_____ CASH

_____ ACH Routing Number_____ Account Number_____

_____ CHECK

_____ CREDIT CARD

_____
NAME ON CREDIT CARD

_____
CREDIT CARD NUMBER

_____
ADDRESS LINKED TO CREDIT CARD

_____ _____
SECURITY CODE EXPIRATION DATE

1580 Centenary Boulevard, Shreveport, Louisiana 71101
318.416.9603

Community School

TERMS AND CONDITIONS

1. THIS TUITION AGREEMENT IS ENTERED INTO BY YOU AND BETWEEN THE COMMUNITY SCHOOL AND THE ABOVE NAMED STUDENTS AND RESPONSIBLE PARTIES FOR 2026-2027 SCHOOL YEAR.
2. TUITION FEES ARE QUOTED IN US DOLLARS AND ANNOUNCED ON A YEARLY BASIS. THE TOTAL TUITION FEE FOR THE COMMUNITY SCHOOL IS $8000 PER ACADEMIC SCHOOL YEAR, SUBJECT TO ANY ADJUSTMENTS AS OUTLINED IN THE SCHOOL'S TUITION POLICY. THIS INCLUDES THE $500 RESOURCE FEE. THIS **DOES NOT** INCLUDE THE $150 SUPPLY FEE.
3. ALL CREDIT CARD AGREEMENTS ARE REQUIRED TO HAVE A VALID AND FUNCTIONING CREDIT CARD ON FILE. COMMUNITY SCHOOL IS AUTHORIZED TO USE THE CREDIT CARD LISTED ABOVE TO PAY THE TUITION FEE IN THE AMOUNT CHECKED ABOVE ON THE DUE DATE. COMMUNITY SCHOOL WILL CHARGE A 3% FEE TO ALL CREDIT CARD TRANSACTIONS.
4. THE RESPONSIBLE PARTY AGREES TO PAY TUITION FEES ON OR BEFORE THE DEADLINE WHICH IS STATED IN THEIR CHOSEN PAYMENT SCHEDULE OPTION.
5. I, THE RESPONSIBLE PARTY, AGREE TO ABIDE BY THE COMMUNITY SCHOOL ENROLLMENT PACKET. I UNDERSTAND THAT IF MY CHILD VIOLATES ANY PORTION OF THE ENROLLMENT PACKET, THAT I AM **NOT** ENTITLED TO A FULL REFUND. IN ADDITION, IN THE EVENT OF A WITHDRAWAL OR DISMISSAL, I UNDERSTAND THAT ALL FEES ARE NON-REFUNDABLE, AND TUITION WILL BE CHARGED THROUGH THE END OF THE LAST MONTH OF ATTENDANCE.

_____ I ACCEPT THE TERMS AND CONDITIONS ABOVE

PLEASE REACH OUT TO BILLING AND ACCOUNTING FOR QUESTIONS REGARDING SETTING UP TUITION PAYMENTS. **THIS TUITION PAYMENT FORM AND SET UP OF TUITION PAYMENT WITH ACCOUNTING IS REQUIRED WITHIN THE FIRST 3 DAYS OF ACTIVE SCHOOL ATTENDANCE.** FAILURE TO SET UP PAYMENT CAN RESULT IN SCHOOL ENROLLMENT AND CORRESPONDING SCHOOL ACTIVITIES TO BE HALTED UNTIL SET UP HAS BEEN COMPLETED. ACCOUNTING CAN BE REACHED AT 318-416-9603 EXT 5 AND/OR RUTH@COMMUNITYSCHOOLSHREVEPORT.COM. AFTER YOUR SUBMISSION IS RECEIVED, YOU WILL RECEIVE AN INVITE TO SIMPLE PRACTICE, OUR BILLING AND PAYMENT PLATFORM, TO YOUR PROVIDED EMAIL WITHIN 1-2 BUSINESS DAYS.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE