REFERRAL PACKET

INSPIRE

Center for Autism

We want to thank you for considering services with Inspire Center for Autism and for providing us with the opportunity to work with your family.

Throughout all phases of treatment, including the referral, intake and registration process at Inspire Center for Autism, our intent is to gain a comprehensive understanding of each individual patient's baseline and present levels of performance, including their strengths and needs. In order to do so, we rely heavily on input from parent(s)/guardian(s), file reviews, and direct and indirect assessments. The information obtained within these processes will provide a basis for treatment recommendations moving forward. If at any time within the process you have questions or concerns or would like clarification, please do not hesitate to reach out for support.

To participate in a referral to Inspire Center for Autism for Applied Behavior Analytic (ABA) services, please review and complete the documents included in this packet. A checklist has been provided below to assist in ensuring all requested documents are reviewed, completed and submitted.

Referral Packet Checklist			
Title of Document	**Location in Packet**	**Date Completed**	**Initials**
Referral for ABA Services	**Pages 3-5**		
Insurance Questionnaire	**Page 6**		
Financial Responsibility Agreement	**Pages 7-9**		
Notice of Privacy Practices (NPP)	**Pages 10-12**		
Release of Information (ROI)	**Pages 13-14**		

A finalized packet will be required prior to the intake being initiated.

Referral for Services			
Date of Referral:		**Referral Completed By:**	
Funding Source:	☐ Insurance, if so what insurance ☐ Private Pay ☐ Single Case Agreement		
Relationship to Individual Being Referred:			
Patient's Name:		**Date of Birth:**	
Age:		**Gender:**	☐ Male ☐ Female
Primary Language:		**Language(s) Spoken at Home:**	
Address:			
Contact Information- Preferred Phone:	(_____) _____ - _____	☐ Home (landline) ☐ Cell	
Contact Information- Preferred Email:			
Name of Parent(s)/Legal Guardian(s):			
Guardianship Status:	☐ Joint home- Both parents are legal guardians ☐ Split home- Single parent guardianship ☐ Split home- Dual parent guardianship	**Court Orders:**	Are there any court orders related to the patient? ☐ Yes. ☐ No If yes, Date: Involving:
Siblings:	Names		Ages
Cultural Considerations:	☐ The following cultural considerations are important for my child's treatment team to be aware of: ☐ There are no cultural considerations that may impact treatment. If any considerations arise in the future, the BCBA will be made aware so they can make necessary modifications/accommodations.		
Reason for Referral (Areas of Concern):	☐ Adaptive and self-help skills ☐ Cognitive functioning ☐ Coping and tolerance skills	☐ Attending (focus/attention to task) ☐ Community participation ☐ Emotional development	

	☐ Family relationships ☐ Play and leisure skills ☐ Reduction of interfering or inappropriate behavior ☐ Self-advocacy and independence ☐ Social relationships ☐ Language and communication ☐ Pre-academic skills ☐ Safety skills ☐ Self-management ☐ Vocational skills
Based on the areas of concern indicated above, the main concerns to our family include (rank ordered):	
What are your goals for assessment, treatment, consultation and/or training?	Assessment: Treatment: Consultation/Training:
Previous Behavior Analytic Services	
Applied Behavior Analytic (ABA) Services:	Has in the individual being referred received ABA therapy in the past? ☐ Yes ☐ No If yes, please list dates of services and providing entity:
Previous ABA Training:	Have the parents previously received any ABA training? ☐ Yes ☐ No If yes, please list dates, presenting entity and topics covered:
ABA Knowledge:	Please rate your confidence in understanding what ABA is: ☐ Not confident at all ☐ Somewhat confident ☐ Well versed in the knowledge of ABA ☐ Well versed in the knowledge and application of ABA

File Review

A file review will be conducted in order to obtain important information related to the individual's background, present levels, and prior assessment results (if applicable). Please see below and indicate which records you have submitted as part of the file review process. Records may include initial reports, quarterly/progress reports, current treatment plans, and/or discharge reports:

☐ Diagnostic Report
☐ Speech-Language
☐ Physical Therapy
☐ Occupational Therapy
☐ Educational Evaluation
☐ Individualized Education Plan
☐ General Medical
☐ Functional Behavior Assessment (FBA)
☐ Behavior Intervention Plan (BIP)
☐ Previous Skills Assessment (i.e. VB-MAPP)
☐ Custodial/Guardian/Court Orders
☐ Other (please specify):
☐ Other (please specify):

Current or Pending Services

Please indicate any and all services that the individual participates in on a regular basis, as well as any services you are currently on a wait list for:

Type of Service *(Speech, OT, PT, etc.)*	Status	Service Provider *(i.e. Aspen)*	Day(s) of Service *(Day of the Week)*	Time of Service *(i.e. 5:00-6:00pm)*
Speech	☐ Current ☐ Wait list			
Occupational Therapy	☐ Current ☐ Wait list			
Physical Therapy	☐ Current ☐ Wait list			
Music Therapy	☐ Current ☐ Wait list			
Habilitation	☐ Current ☐ Wait list			
Respite	☐ Current ☐ Wait list			
Behavioral Health	☐ Current ☐ Wait list			
School/daycare	☐ Current ☐ Wait list			
Other	☐ Current ☐ Wait list			

Availability

ABA sessions through Inspire Center for Autism are typically 2-3 hours in duration and scheduled in advance for 90 days at a time. With that in mind, please indicate the hours during the week that the individual is available for ABA services.

Time	Monday	Tuesday	Wed.	Thursday	Friday	Saturday
7:00-8:00am	☐	☐	☐	☐	☐	☐
8:00-9:00am	☐	☐	☐	☐	☐	☐
9:00-10:00am	☐	☐	☐	☐	☐	☐
10:00-11:00am	☐	☐	☐	☐	☐	☐
11:00am-12:00pm	☐	☐	☐	☐	☐	☐
12:00-1:00pm	☐	☐	☐	☐	☐	☐
1:00-2:00pm	☐	☐	☐	☐	☐	☐
2:00-3:00pm	☐	☐	☐	☐	☐	☐
3:00-4:00pm	☐	☐	☐	☐	☐	☐
4:00-5:00pm	☐	☐	☐	☐	☐	☐
5:00-6:00pm	☐	☐	☐	☐	☐	☐
Total Hours						

Family Commitment to ABA Services

Based on the results of the pending assessment, our family is willing and able to be present and participate in ABA services for the following:

☐ **0-10 hours/week of services** (including 1:1 treatment implementation and parent training)
☐ **10-20 hours/week of services** (including 1:1 treatment implementation and parent training)
☐ **20+ hours/week of services** (including 1:1 treatment implementation and parent training)

Insurance Questionnaire *Failure to disclose primary or secondary (where applicable) insurance could result in the termination of services.*			
Name of Patient:		**Date of Birth:**	
Primary Coverage Policy Holder's Information			
Name of Policy Holder:		**Date of Birth:**	
Address:		**Phone Number:**	
Name of Insurance Carrier:		**Insurance Phone Number:**	
Insurance Billing Address:			
Contract Number/ID Number:		**Group Number:**	
Employer Name:			
Secondary Coverage Policy Holder's Information (Please Include AHCCCS/DDD)			
Name of Policy Holder:		**Date of Birth:**	
Address:		**Phone Number:**	
Name of Insurance Carrier:		**Insurance Phone Number:**	
Insurance Billing Address:			
Contract Number/ID Number:		**Group Number:**	
Employer Name:			
I, _____, the legal guardian of _____, give my consent for Inspire Center for Autism to contact my insurance carrier (named above) to verify coverage for behavior analytic services and/or to bill my insurance for any services rendered by the staff at Inspire Center for Autism.			
Signature of Policy Holder:		**Date:**	

Please submit a copy of the front and back of your insurance card for future reference.

Financial Responsibility Agreement			
Patient's Name:		**Date of Birth:**	

Insurance	The Board-Certified Behavior Analysts® (BCBAs®) at Inspire Center for Autism are credentialed through Blue Cross Blue Shield (BCBA), United Health Commercial Plan, and UHCCP to provide services to individuals who have covered benefits through their private insurance or community plans. Inspire Center for Autism will ensure that all pre-authorization, assessment and progress reports are completed and submitted before the due dates to continue ongoing services. However, if any claim comes back as uninsurable, the patient and/or guardian will be billed for the full amount of services after 60 days. As such, it will be the responsibility of the patient and/or guardian to contact the insurance company to request reimbursement. The patient and/or guardian is responsible for any charges, or portions of charges that their insurance company does not cover. Inspire Center for Autism will release all necessary paperwork to the patient or guardian as requested for insurance reimbursement requests.
Private Pay	Inspire Center for Autism accepts personal payments in the form of cash, check, credit or debit. Inspire Center for Autism charges $125.00/hour for all services rendered under the private pay option. However, families have the option of purchasing hours in bulk at a discounted rate. For more information regarding the bulk hour purchasing and additional private pay agreements, please contact Inspire Center for Autism.
Single-Case Agreements	Inspire Center for Autism may consider engaging in single-case agreements with out-of-network providers, industry contacts, local school districts or through the Empowerment Scholarship Accounts (ESA). Please refer to the conditions listed under "Insurance" for more information regarding the patient and/or guardian responsibility.

During the term of this agreement, Inspire Center for Autism will provide behavior analytic services as described below, based on the individual patient's treatment recommendations, and in the terms and conditions specified.

Assessment	Throughout all phases of treatment, consistent, ongoing and objective assessments will take place to ensure a comprehensive understanding of each individual's baseline, present levels of performance and progress across environments. An analysis of the information obtained through the assessments will serve as the basis for ongoing treatment recommendations. Assessments conducted by the staff at Inspire Center for Autism may include, but are not limited to, parent interviews, file reviews, the Assessment of Basic Language and Learning Skills, Revised (ABLLS-R), the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), The Essentials for Living (ELS), the Assessment of Functional Living Skills (AFLS), the Vineland Adaptive Behavior Skills, and/or Functional Behavior Assessments (FBA).

Treatment Implementation Models:	**Comprehensive ABA**	Comprehensive ABA treatment typically involves 30-40 hours of direct 1:1 therapy and is designed to address multiple domains that impact an individual's ability to function at the same level as their typically developing peers. Gaining new skills (skill acquisition) and reducing barriers that may impede an individual's involvement in home, community or educational opportunities (behavior reduction) are the primary objectives within a comprehensive ABA treatment approach.
	Focused ABA	Focused ABA treatment typically involves 10-25 hours of direct 1:1 therapy and is designed to address a limited number of domains for individuals who only need to target key functional skills or for individuals in which the priority of treatment is a reduction in significant maladaptive behaviors. The primary objectives within a focused ABA treatment approach include targets that increase independence and/or improve the health or safety of the individual or others.
Parent Training:	Parent/caregiver training is a required component of treatment and is designed to improve an individual's ability and likelihood of implementing treatment protocols and recommendations outside of direct treatment and across environments. The primary objectives within a parent/caregiver training model are coaching, modeling, problem solving, support, and generalization through the use of objective and measurable goals for parents/caregivers.	
Data Analysis and Treatment Modifications:	Throughout treatment at Inspire Center for Autism, on-going data analysis will be conducted to monitor patient progress toward treatment plan goals. Data analysis will include, but is not limited to, the review of data collection systems, summarizing and reporting patient progress towards treatment goals. Based on data analysis, the staff at Inspire Center for Autism may adjust treatment protocols and/or modify treatment recommendations.	
Tiered Service Delivery Model:	Inspire Center for Autism utilizes a tiered service-delivery model, in which the Board Certified Behavior Analyst (BCBA)® on the case designs, supervises, and provides clinical direction, while the treatment protocols are delivered by the Registered Behavior Technicians (RBT®). In some cases, the BCBA will provide direct treatment to the patient.	
Coordination of Care:	In an effort to improve patient outcomes, the staff at Inspire Center for Autism will consult and/or collaborate with other professionals involved in the patient's care. Coordination of care between professionals and family members can help ensure consistency across environments. Coordination of care may include, but is not limited to, emails, phone calls, in-person meetings, and/or trainings. Explicit consent from the patient's legal guardian to obtain and/or release information for the purpose of coordination of care will be obtained by Inspire Center for Autism prior to doing so.	

I, _____, the legal guardian of _____ agree to the terms of the above financial agreement.

Printed Name of Guardian:		**Date:**	
Signature:			

4904 S. POWER RD., STE. 103-226
P: (480) 269-7709
MESA, AZ 85212
HTTP://INSPIRECENTERFORAUTISM.COM

Notice of Privacy Practices (NPP)			
Patient Name:		**Date of Birth:**	

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Inspire Center for Autism is required by law to maintain the privacy of protected health information (PHI) for each patient and/or potential patient. This notice provides information regarding how Inspire Center for Autism may use and disclose protected health information (PHI) about a patient and the patient's rights with regard to the disclosure(s) of information, along with the patient's right to complain of a violation.

Protected health information includes the following and may include information that is held or transmitted in paper and/or electronic form:

Patient's name	Street, city, precinct, zip code	Telephone number
Account number	Fax number	Email addresses
Social security number	Medical record number	Health plan beneficiary numbers
Dates related to a patient, including birth date, admission date, discharge date, etc.	Certificate of license numbers	Vehicle identifiers, serial numbers, license plate numbers
Device identifiers and serial numbers	Web Universal Resource Locators (URLs)	Internet protocol (IP) address numbers
Biometric identifiers, including finger and voice prints	Full face, photographic images and any comparable images	Any other unique identifying number, characteristic or code

A patient's PHI may be used or disclosed by Inspire Center for Autism with the written consent/authorization of the patient and/or guardian. This written consent/authorization will be obtained internally using a Release of Information (ROI), which allows the patient and/or guardian to clearly identify to whom and from whom Inspire Center for Autism may release and/or obtain PHI from.

It is important to note that there are several instances, under the Privacy Law, in which Inspire Center for Autism may disclose PHI without the consent of the patient and/or guardian. Permitted and required uses and disclosures that may be made without written consent/authorization, or the opportunity to agree or object to such disclosures may include:

Treatment and Payment	A patient's PHI may be disclosed to another entity for treatment and payment purposes related to billing and/or getting payment from health plans (i.e. insurance company).
Operations of Inspire Center for Autism	The minimum necessary protected health information may be disclosed to individuals within Inspire Center for Autism who are involved in the direct care of the patient or individuals who are involved in other pertinent business operations related to the services being delivered, such as referrals, intakes, registration, quality assurance, auditing, and billing.

Exceptional Situations	**Emergency Situations:** If immediate action is required to save a patient's life and/or prevent permanent damage, Inspire Center for Autism may release PHI to the appropriate authorities. **Abuse, Neglect and/or Domestic Violence**: If an Inspire Center for Autism staff member witnesses or suspects abuse or neglect of an individual, he/she is mandated to make a report to the appropriate public authorities. **Danger:** If an Inspire Center for Autism staff member suspects that you are in imminent danger of harming yourself or someone else, he/she is mandated to make a report to the person at risk to the public authorities. **Communicable Diseases:** Inspire Center for Autism is required to report when patients have certain communicable diseases. **Medical Devices:** Inspire Center for Autism is required to report any medical device malfunction or loss of functionality. **Legal Proceedings:** Inspire Center for Autism staff members may disclose PHI in response to a court order or subpoena or certain other legal proceedings as required by law.

As outlined in HIPAA, it is our responsibility at Inspire Center for Autism to also inform you of your patient rights related to the protected health information that Inspire Center for Autism maintains related to the services we provide and your individual records (electronic and/or paper). Please see below for a list of your rights.

Right to Access, Inspect or Obtain Copies	Patients have the right to access, inspect and obtain copies of information that may be used to make decisions about their care. To inspect and receive copies of information, a written request must be submitted. If a copy of the information is requested, Inspire Center for Autism may charge a fee for the cost of copying, mailing, or other supplies associated with the request. Inspire Center for Autism must respond to the request within fifteen days of receipt.
Right to Request Restrictions on Uses and Disclosures	A patient may request that the disclosure of confidential information be limited or restricted. Requests related to restrictions in disclosures related to treatment and payment may be denied by Inspire Center for Autism, unless the patient pays privately (i.e. in cash) for services rendered. Services provided to private pay patients do not have to be reported to the patient's health plan.
Right to Request Corrections or Amendments	If a patient feels that the PHI about them is incorrect or incomplete, they may ask Inspire Center for Autism to amend the information. Patients have a right to request an amendment for as long as Inspire Center for Autism keeps the information. A request for an amendment must be in writing and must provide a reason supporting the request. Requests may be denied if the information was not originated by Inspire Center for Autism, the originator of the information is no longer available, or if the information is accurate and complete.

Right to Request Alternate Means of Transmission of PHI	A patient has the right to request the transmission of PHI to alternate locations or by alternate means (i.e. different address or phone number) by submitting the request in writing. The appropriateness of the request will be reviewed by Inspire Center for Autism and the patient will be informed of the decision (accepted or denied).
Right to an Accounting of Disclosures	Patients have the right to request an accounting of disclosures regarding information that Inspire Center for Autism has disclosed regarding their PHI. A request must be submitted in writing to the above address. A request must state a period for the disclosures, which may not be longer than six years and may not include dates before June 15, 2018.
Right to a Paper Copy of this Notice of Privacy Practices	Patients have a right to a paper copy of the signed Notice of Privacy Policies.
Right to File a Complaint	If a patient feels as though their rights related to the protection and disclosure of their protected health information (PHI) has been violated, they have a right to make a complaint by contacting Zachary Rudolph at Inspire Center for Autism directly at 480-269-7709 or via email at zruldoph@inspireautismcenter.com Patients may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or calling 1-877-696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

This notice may be amended as needed to comply with federal, state, and professional requirements. If/when Inspire Center for Autism's Notice of Privacy Practices is updated, a new copy will be provided to all patients.

Notice of Privacy Practices Receipt Form			
I, _____, the legal guardian of _____ have read and received a copy of the Notice of Privacy Practices from the staff of Inspire Center for Autism.			
Printed Name of Guardian:		**Date:**	
Signature:			

Authorization to Release and/or Obtain Information (ROI)			
Patient Name:		**Date of Birth:**	
I hereby authorize Inspire Center for Autism to obtain and/or release confidential protected health information (PHI) related to the patient named above, for the purpose of the continuity of care (coordination of care). I understand that the exchange of information may be done verbally, in-person, through email (or other written form), and/or telephone and will be handled with strict confidentiality and in the best interest of the patient. The consent provided herein for the exchange of information will be renewed annually, unless terminated prior to the annual expiration by written notification. In the event that services with Inspire Center for Autism come to an end, my authorization will automatically expire 30 days after the termination of services or at an earlier time by written notification.			
Name of Parent/Guardian:		**Date of Consent:**	
Signature:			

Information may be exchanged with the following individuals and/or agencies as indicated:

☐ **Insurance Company:**	Name: Phone:	Email: Fax:
☐ **Pediatrician:**	Name: Phone:	Email: Fax:
☐ **School District:**	Name: Phone:	Email: Fax:
☐ **Psychologist:**	Name: Phone:	Email: Fax:
☐ **Family Member:**	Name: Phone:	Email: Fax:
☐ **Caregiver:**	Name: Phone:	Email: Fax:
☐ **Speech-Language Pathologist:**	Name: Phone:	Email: Fax:
☐ **Occupational Therapist:**	Name: Phone:	Email: Fax:
☐ **Physical Therapist:**	Name: Phone:	Email: Fax:
☐ **Neurologist:**	Name: Phone:	Email: Fax:
☐ **Other:**	Name: Phone:	Email: Fax:
☐ **Other:**	Name: Phone:	Email: Fax:

I hereby request that no confidential health information related to the patient named above, be released to and/or obtained by Inspire Center for Autism, for the following individuals or agencies:

☐ Name:	Phone:	Email:	
☐ Name:	Phone:	Email:	
☐ Name:	Phone:	Email:	
☐ Name:	Phone:	Email:	
☐ Name:	Phone:	Email:	
Name of Parent/Guardian:		**Date of Request:**	
Signature:			