

Intake Packet Checklist

Client Initials: _____

Date: _____

	Items	Initials	Date Complete
<input type="checkbox"/>	<u>Welcome Page</u> ***		
<input type="checkbox"/>	<u>Financial Responsibility Agreement</u> ***		
<input type="checkbox"/>	<u>Non-Violent Physical Crisis Intervention</u> ***		
<input type="checkbox"/>	<u>Permission for Assessment</u> ***		
<input type="checkbox"/>	<u>General Consent for Care and Treatment</u> ***		
<input type="checkbox"/>	<u>Mandated Reporter</u> ***		
<input type="checkbox"/>	<u>Abuse and Molestation Prevention</u> ***		
<input type="checkbox"/>	<u>Notice of Privacy Practices</u> ***		
<input type="checkbox"/>	<u>Agreement to Videotape/Audiotape/Photograph</u> ***		
<input type="checkbox"/>	<u>Authorization and Consent to Participate in Telehealth Consultation</u> ***		
<input type="checkbox"/>	<u>Professional Release of Information</u> **		
<input type="checkbox"/>	<u>Agency Representative Descriptions</u>		
<input type="checkbox"/>	<u>Medical Questionnaire</u>		
<input type="checkbox"/>	<u>Client Information</u>		
<input type="checkbox"/>	<u>Risk Assessment</u>		
<input type="checkbox"/>	<u>Client Home Safety Checklist</u>		

***Must be discussed and signed at the beginning of the intake

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ALL DOCUMENTS MUST BE SIGNED AND REVIEWED BY THE END OF THE ASSESSMENT

Welcome to the Apex Therapy Services Family!

Apex Therapy Services is pleased to have you join us. We ensure that we are a highly inclusive, culturally sensitive, culturally respectful, and culturally competent organization. We will make every effort to ensure you are always treated with respect and dignity, in consideration of the following (but not limited to): racial, ethnic, or cultural customs, practices, and beliefs; sexual orientation; gender, gender identity, and gender expression; disability, and community differences.

Apex Therapy Services is committed to taking reasonable steps to ensure that those with Limited English Proficiency (LEP) have meaningful access and equal opportunity to participate in our services, activities, and programs. It is our policy to ensure that all who need help can access help, either at our agency or at another suitable location. To this end, we are committed to help those who do not speak English, those that use non speech based alternative communication methods and those who do not use a standard method of language at all (i.e. nonverbal clients)- This commitment is further demonstrated in our adherence to the Apex Therapy Services Language Access Plan.

Client Name: _____

Client Signature: _____

Date: _____

Financial Responsibility Agreement

Apex Therapy Services aims to help as many clients/families as possible, and we seek out various funding opportunities, including insurance, state, county, and self-funding.

Insurance:

Apex Therapy Services will ensure that all pre-authorization, assessment, and progress reports are completed and submitted before the due dates to continue ongoing therapy. You and the insurance provider may be responsible for any charges, or portions of charges which are not covered. Apex Therapy Services will release all necessary paperwork to the client or Parent(s)/Guardian(s) as requested.

Apex Therapy Services is currently **in network** with the following insurance companies:

Insurance Company	In network as of: (date)
Blue Cross Blue Shield of Michigan	1/1/2024
Aetna PPO	1/1/2024
Cigna	3/26/2024

Apex Therapy Services is currently **out of network** with the following insurance companies.

- United Healthcare
- Health Alliance Plan
- Priority Health

Please note that the lists above may not be all-inclusive and are subject to change. If you have any questions regarding insurance coverage, please contact the Apex Therapy Services Billing and Finance department at (248) 712-1129.

No Surprises Act (no Balance Billing):

If your insurance company falls under the out-of-network classification, Apex Therapy Services will ensure that you are not billed for the difference between the billed charge and the amount your insurer pays.

State or county-funding:

If your insurance is funded through the state or county, Apex Therapy Services will ensure all assessment and progress reports are completed and submitted before the due date, to continue ongoing therapy.

Apex Therapy Services promises to not exceed the total funded amount without the expressed consent of the client and/or Parent/Guardian. However, if you request additional sessions above and beyond the funded amount, you will be responsible for payment of these additional services.

Before beginning any additional sessions, the supports coordinator/case manager will be notified, and a client contract will be signed with the total amount of sessions above the funded amount.

Self-Funded:

Apex Therapy Services and the Parent/Guardian will determine the number of ABA therapy hours per week and supervision per month, but at a minimum, the BACB requires supervision occur for 5% of hours spent providing behavior analytic services each month (or 30 minutes of supervision for every 10 hours of ABA therapy provided).

The Parent/Guardian will receive a monthly bill, with payment due within 30 days of the invoice date. If payment is not received within 30 days of the invoice date, then Apex Therapy Services has the right to place the account on hold and stop services until payment has been received in full.

The two options for Self-Funded clients are:

Pre-Pay:

If you pre-pay for monthly ABA services, you will receive a timely payment rate, which is based on the agreed amount. The following criteria must be met to qualify for the pre-pay plan:

1. An ABA Technician trained and supervised closely by the ABA Supervisor must conduct at least 50% of all therapy sessions.
2. Payment must be received on or before the due date as written on the invoice (within 30 days from the date of the invoice).
3. All documents must be signed and returned within 72 hours of receipt. If additional time is required, please discuss this with an Apex Therapy Services team member.

The pre-paid rate will increase to the standard hourly rate if you are unable to meet the above terms. In the case of non-compliance, you will receive an email within 48 hours and be notified of the rate increase. After one incident of non-compliance, you can return to pre-pay rates following successful payment of the three terms of standard rates. However, if payment is not received within 30 days of the due date printed on the invoice, Apex Therapy Services reserves the right to place services on hold until payment is received in full.

Standard Rate:

Services will be billed at the standard hourly rate. Payment must be received no later than 30 days of the invoice date (due date will be posted on the invoice). If payment is not received by the due date as stated on invoice, there will be a late charge of \$60.00 applied to your account, and Apex Therapy Services reserves the right to place services on hold until payment is received in full.

Pre-pay Rates	Standard Rates
ABA Technician: \$30 per hour	ABA Technician \$40 per hour
ABA Supervisor \$80 per hour	ABA Supervisor \$100 per hour

*We maintain an up-to-date fee schedule on your online account.

Parent(s)/Guardian(s)/Responsible Party are given at least 60 days' notice of any fee changes.

Time is billed in 15 minutes increments.

The terms of this agreement will continue until either party provides written notice of termination request. Termination will take place 30 days from the date of the request, and termination reports (a minimum of 4 hours billed at the ABA Supervisor rate) will be provided at the time of termination. If a notice of termination is not provided in writing, one week of service will be billed to you

Invoices:

Apex Therapy Services will invoice clients/families monthly. You will receive an itemized invoice, with a breakdown of the date of service, time of service, and service type. You will receive an electronic invoice on the last day of each month. Paper copies are available upon request; to receive a paper copy, please contact the Apex Therapy Services Billing and Finance department at (248) 712-1129.

The Parent(s)/Guardian(s)/responsible party of the client receiving services remain completely responsible for the full payment of all services, including late payment fees. We accept payment via online banking, check, money order, debit, or credit cards (Visa, MasterCard, Discover, or American Express). It is recommended that clients use online banking where possible.

Fees:

- There is a \$40.00 Returned Check Fee for all checks returned by the bank.
- Appointments must be canceled at least 24 hours in advance. If they are not canceled with 24 hours' notice, you will be charged a \$60.00 missed appointment fee.
- There is a late Payment charge of \$60.00 as described above.
- Any requests for printed records will take up to 30 days and cost \$0.25 per page.

Payment Agreement:

Please initial which type of payment terms you are requesting.

- I have insurance coverage and authorize direct payment from my insurance carrier to Apex Therapy Services. _____ **(Please initial)**
- I have county/state funding; all claims will be paid by the government-funding source. _____ **(Please initial)**
- I do not have insurance coverage or county/state funding and understand that I am responsible for payment of all charges. I have elected to self-fund the pre-payment rate; ABA Supervisor rates are \$80 dollars an hour. ABA therapy rates are \$30 dollars an hour. I am requesting _____ hours of ABA therapy per week and understand that for every 10 hours of ABA Therapy, there will be a charge of 1 hour of supervision at the ABA Supervisor rate. _____ **(Please initial)**
- I do not have insurance coverage or county/state funding and understand that I am responsible for payment of all charges. I have elected to self-fund at the standard payment rate; ABA Supervisor rates are \$40 dollars an hour. ABA therapy rates are \$100 dollars an hour. I am requesting _____ hours ABA therapy per week and understand that for every 10 hours of ABA therapy, there will be a charge of 1 hour of supervision at the ABA Supervisor rate. _____ **(Please initial)**

ABA Therapy Service Agreement

During the term of this agreement, Apex Therapy Services will provide ABA Therapy services, and the client/responsible party will compensate Apex Therapy Services with payment for the services as described below in the terms and conditions specified. I understand all the fees and conditions as stated above.

IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.

Services

During the terms of this agreement Apex Therapy Services shall provide the following services:

Behavioral treatment services, which may include, but are not limited to:

- Direct one-on-one instruction,
- A continuation of assessments, and modification of programs (data collection and review as required for evidence-based ABA practices),
- Completion of Functional Behavior Assessment (FBA) or Functional Analysis (FA) for problem behaviors,
- An update of Behavior Intervention Plan (BIP), and
- Parent/Guardian training/Family Treatment Guidance

Other professional services can be requested but are not included in this service agreement may include, but are not limited to:

- Program development
- Attendance at meetings or consultations with other professionals you have authorized
- Preparation of records or treatment summaries
- Time required to perform any other service which you may request

I agree to the terms of the above agreement.

Client Name: _____

Client Signature: _____

Date: _____

Nonviolent Physical Crisis Intervention Release

Apex Therapy Services utilizes Nonviolent Crisis Intervention provided by Quality Behavior Solutions (QBS)/Safety-Care as a crisis prevention and management system. All Agency Representatives that may be involved in physical intervention are trained and certified in Nonviolent Crisis Intervention. Please be aware that parent(s), guardian(s), or other individuals involved in treatment cannot be trained by our Agency Representatives in personal safety techniques and physical interventions (i.e., restraints).

Nonviolent Crisis Intervention's philosophy is Care (showing compassion and empathy); Welfare (supporting emotional and physical well-being); Safety (preventing danger, risk, and injury); and security (ensuring harmony-not harm). The focus of Nonviolent Crisis Intervention is on the client and emphasizes the importance of being supportive and maintaining therapeutic rapport. All Agency Representatives have been trained to understand the levels of crisis development, how each level of crisis should be approached, and how to proactively prevent any need to use physical intervention by teaching replacement behaviors.

Nonviolent physical crisis intervention utilizes safe, non-harmful control and restraint positions to safely assist an individual until he/she can regain control of their behavior. Physical management will only be utilized as a last resort when all other less restrictive strategies have been exhausted, or when a person is considered a danger to self or others, according to the procedures provided by QBS Safety-Care per policies established by Apex Therapy Services. A serious incident will be documented in a written report and reviewed with the client, the client's parent(s)/guardian(s) and any witnesses. The report will be submitted to the Program Director and placed in the client's file.

When addressing problem behaviors, client's care, welfare, safety, and security will be our primary focus. Nonviolent Physical Crisis intervention will always be a measure only used to ensure the safety of clients and others. If you have any questions or concerns regarding this policy, please contact Apex Therapy Services at any time.

If you choose to decline the use of physical intervention, Apex Therapy Services Agency Representatives including, at minimum, the Program Director, ABA Supervisor, and ABA Technician(s) will assess the level of risk in the home and if services can continue to be provided safely without the use of physical intervention.

Please initial your preference below:

- I prefer that my ABA team provide me with assistance when physical redirection is needed.
_____ (please initial)
- I prefer that assistance with physical redirection only be provided by the following individuals listed below: _____ (please initial)

- I prefer we both work together to assist me when physical redirection is needed.
_____ (please initial)
- I decline the use of physical intervention during therapy sessions.
_____ (please initial)

I have fully read, understand, and have inserted my initial next to my preference to the above in this Nonviolent Physical Crisis Intervention Release.

Client Name: _____

Client Signature: _____

Date: _____

Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____

Permission for Assessment – Adult

I give my permission to be evaluated and assessed by Apex Therapy Services to determine initial and continuing eligibility for services. I understand that this information will also be used to identify my strengths and areas of need for determining appropriate intervention services and programming.

Client Full Name:	Client Date of Birth:
Client Signature	Date:
Apex Therapy Services Agency Representative Signature:	Date:

General Consent for Care and Treatment

TO THE CLIENT: You have the right, as a client, to be informed about your condition and the recommended treatment to be used so that you may make the decision whether or not to undergo any suggested treatment after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or assessment for any identified area(s) of need.

This consent provides us with your permission to perform reasonable and necessary assessment, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a treatment recommendation; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your ABA Supervisor about the purpose, potential risks, and benefits of any treatment. If you have any concerns regarding any assessment or treatment recommended by your BCBA, we encourage you to ask questions.

I voluntarily request an ABA Supervisor to perform reasonable and necessary assessments and treatment for the condition, which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Client Name: _____

Client Signature: _____

Date: _____

Name of Witness and Title: _____

Signature of Witness: _____

Date: _____

Mandated Reporter Disclosure Form

All clinical Agency Representatives of Apex Therapy Services are mandated reporters as deemed so by Michigan state rules, regulations, and laws. This is true of all therapists, social workers, teachers, etc., and should not restrict the work to be completed. This is a state law designed to protect children and vulnerable adults from injury and should not be viewed as a means to harm Parent(s)/Guardian(s) or other individuals involved in the client's care.

This form shall serve as a reminder to the client/family of this fact and shall also provide insight into what this disclosure means. This disclosure shall serve as part of the client's/family's education regarding the program, and the client information packet.

Being deemed a mandated reporter, all Agency Representatives of Apex Therapy Services are required by law to report any and all allegations, reports, and suspicions of abuse, neglect, and maltreatment of a child or vulnerable adult immediately to the appropriate identified governing body. The Agency Representative, who is the mandated reporter, should also notify their immediate supervisor, who may then assist the Agency Representative with making the report.

The Department of Human Services is the governing body identified in the state of Michigan regarding cases of abuse, neglect, and maltreatment of a child or vulnerable adult and the Agency Representative is required and shall, therefore, report the incidents mentioned above to the appropriate governmental agency.

Any report made to the Department of Human Services where deemed necessary by them, shall constitute a separate case from the services managed by Apex Therapy Services. Apex Therapy Services shall play no part in decisions made by Department of Human Services and should be viewed as a separate organization.

The client (or client's parent(s)/guardian(s)) shall sign a Mandated Reporter Disclosure Receipt Form that shall be kept in the client's file as evidence that the information mentioned above has been provided to the client and family.

Mandated Reporter Disclosure Receipt Form

I, _____, have read and received a copy of the Mandated Reporter Disclosure Form policy from Apex Therapy Services.

Client Name: _____

Client Signature: _____

Date: _____

Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____

Abuse and Molestation Prevention

To help protect children and vulnerable adults, Apex Therapy Services has implemented the following Abuse and Molestation Prevention policy. It is important that all Apex Therapy Services Agency Representatives understand and apply these guidelines in order to prevent abuse against children and vulnerable adults. The policies contained herein provide our Agency Representatives and volunteers with the definitions, guidelines, protection, and prevention rules, as well as the policy Acknowledgement, which is required to be signed by all individuals interacting with children and vulnerable adults. .

Purpose

These procedures are designed to reduce the risk of child and vulnerable adult abuse in order to:

- Provide a safe and secure environment for children, youth, adults, visitors, and Agency Representatives.
- Assist Apex Therapy Services in evaluating a person's suitability to supervise, oversee, and/or exert control over the activities of children and vulnerable adults.
- Satisfy the concerns of parents/guardians and Agency Representatives with a screening process for all Agency Representatives.
- Provide a system to respond to alleged victims of sexual abuse and their families, as well as the alleged perpetrator.
- Reduce the possibility of false accusations of sexual abuse made against Agency Representatives.

Definitions

The following terms used herein and are defined as follows:

1. *Agency Representative*: Any director, officer, employee, agent, advisor, staff member, subcontractor, consultant, volunteer, or any other person acting for or on behalf of Apex Therapy Services.
2. *Children/Youth/Minor*: Any person who has not reached his/her 18th birthday or the age of majority as defined by Michigan law.
3. *Adult*: Any person who has reached his/her 18th birthday or as defined by Michigan law.
4. *Volunteer*: Means any unpaid person engaged in or involved in activities and who is entrusted with the care and supervision of minors or a person who directly oversees and/or exerts control or oversight over minors or adults.
5. *Sexual Abuse*: is defined as the use, persuasion, inducement, enticement, or coercion of any individual to engage in, or assist any other individual to engage in, conduct deemed as sexually explicit conduct, the physical act of rape, and in cases of caretaker or family relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of an individual, or incest as defined by federal and Michigan law. This includes but is not limited to any unwelcomed sexual verbal comments, remarks, sexual gestures, jokes, advances, or leering; sexual touching, fondling, molestation, assault, or any other intimate physical contact; using threats, fear, or undue influence to compelling another individual to engage in a sexual act; and displaying or distribution of pornographic materials to another individual.
6. *Child Emotional Abuse*: Verbal or nonverbal conduct including mental exploitation, degrading, humiliating, or threatening conduct or communications that may or may not include bullying as defined by Michigan law.

Protection and Prevention

Agency Representative Screening Procedures

The following screening procedures are to be used with Agency Representatives who are entrusted with the care and supervision of minors, vulnerable adults, or a person who directly oversees and/or exerts control or oversight over minors/vulnerable adults. All information collected should be maintained in confidence.

Employment Application and Volunteer Application: Any paid Agency Representative or volunteer who will work with a minor must complete the Employment Application.

The statement of release included with the application must be signed by the Agency Representative or volunteer completing the application in order to apply for and qualify for service.

Apex Therapy Services applications include questions regarding:

- Current and previous residence addresses.
- Current and previous employment, to include addresses, dates, duties, titles, and reasons for leaving.
- Names and addresses of schools attended; degree(s) earned.
- References from previous employers and organizations that work with children and/or vulnerable adults
- Criminal history information, as well as pending criminal charges (where not prohibited by state law).

Applications include a statement, which the applicant should acknowledge in writing, certifying all statements provided in the application are true and complete, and any

misrepresentation or omission may be grounds for rejection of the applicant or for dismissal if they are employed.

This statement authorizes Apex Therapy Services to contact any individual or organization listed in the application.

Review all statements made in the application, paying specific attention to any gaps in time and irregular employment patterns or unexplained absence. Pursue these gaps with employers listed and in a subsequent interview.

Interviews will be conducted with all qualified applicants.

If detrimental information is uncovered but the applicant remains desirable, discuss this information with the applicant. In the event the applicant is ultimately hired or accepted as an Agency Representative or volunteer, document the reasons for overriding the prior information.

Whenever possible, Apex Therapy Services will have an associate participate in the interview.

Contact all listed references and employers for paid Agency Representatives. Inquire as to the reason the applicant left and ask for any information that might help determine the applicant's suitability for the position. If a response is not received within a reasonable period of time, follow up and keep notes if possible.

Criminal Background Check: Apex Therapy Services will conduct a criminal background check on all Agency Representatives who are entrusted with the care and supervision of minors and/or vulnerable adults, or a person who directly oversees and/or exerts control or oversight over minors and/or vulnerable adults All criminal background checks will be updated annually.

Confidentiality

Information obtained through the screening, application, reference check, interview, and criminal background check will be kept in confidence, unless otherwise required by law. All information determined during the course of screenings referenced above will remain in a secure location, with restricted access and said materials will be archived.

Supervision Procedures

Unless an extenuating situation exists, Apex Therapy Services:

- Will have an adequate number of screened and trained Agency Representatives present at events involving minors and/or vulnerable adults. Supervision will increase in proportion to the risk of the activity.
- Will monitor facilities during activities involving children and/or vulnerable adults
- Will release minors/vulnerable adults only to an individual listed by the custodial parent/guardian on the “release sheet” and utilize sign-in and sign-out sheets.
- Will require young children who can independently toilet themselves be accompanied to the restroom and the Agency Representative will wait outside the facility to escort the child back to the activity. Whenever possible, the escort will be the same sex as the minor.

Behavioral Guidelines for Agency Representatives

All Agency Representatives will observe the following guidelines:

- Do not provide alcoholic beverages, tobacco, drugs, contraband, or anything that is prohibited by law to minors.

- To the extent possible, Apex Therapy Services events that are co-educational will have both male and female chaperones.
- Whenever possible, at least two unrelated paid Agency Representatives will be in the room when minors are present.
- Doors will be left fully open if one adult needs to leave the room temporarily and during arrival to the class or event before both adults are present. Speaking to a minor or minors one-on-one should be done in public settings where paid Agency Representatives or volunteers are in sight of other people.
- Avoid all inappropriate touching with minors. All touching shall be based on the needs of the individual being touched, not on the needs of the Agency Representative. In the event a minor initiates physical contact and/or inappropriate touching, it is appropriate to inform the minor that such touching is inappropriate.

Never engage in physical discipline of a minor. Agency Representatives shall not engage in activities which could be abusive to minors, including but not limited to physical, verbal, mental, emotional, and sexual abuse.

It is imperative to maintain clear and professional boundaries at all times. If you recognize an inappropriate relationship developing between any minor/vulnerable adult and adult, take action to refer the minor to another individual with supervisory authority.

Anyone who observes abuse of a minor or vulnerable adult will take appropriate steps to immediately intervene and provide assistance. Report any inappropriate conduct to the proper authorities and officials of Apex Therapy Services for handling.

Disqualification

No person may be entrusted with the care and supervision of minors/vulnerable adults or may directly oversee and/or exert control or oversight over minors/vulnerable adults who has been convicted of the offenses, have been on a probation or received deferred adjudication, outlined, or presently has pending criminal charges for any offense outlined below until a determination of guilt or innocence has been made, including any person who is presently on deferred adjudication. The following offenses disqualify a person from care, supervision, control, or oversight of minors:

- Any offense against minors or vulnerable adults as defined by state law.
- A misdemeanor or felony offense as defined by state law that is classified as sexual assault, indecency with a minor or adult, assault of a minor or adult, injury to a minor or adult, abandoning or endangering a minor, sexual performance with a minor or adult, possession or promoting child pornography, enticing a minor, bigamy, incest, drug-related offenses, or family violence.
- A prior criminal history of an offense against minors or vulnerable adults.

Apex Therapy Services will respond promptly to investigate any accusation of sexual abuse. All accusations of sexual abuse will be taken seriously. It is important to be appropriately respectful to the needs and feelings of those who allege sexual abuse and those who have been accused of sexual abuse.

When an allegation is made involving sexual abuse, the person reporting the complaint is to be told about the guidelines and the procedures to be followed. An Apex Therapy Services appointed person will begin investigating the allegations and may use the assistance of legal counsel or other consultants. If the Apex Therapy Services appointed person is the individual

accused of sexual abuse, then the next highest-ranking official of Apex Therapy Services will conduct the investigation.

The investigation will be conducted as follows:

- Report the incident to appropriate authorities in accordance with the state mandatory reporting laws.
- Report the matter to Apex Therapy Services' insurance carrier.
- Cooperate with authorities and the insurance carrier.
- Apex Therapy Services may suspend the alleged offender while a confidential investigation is being conducted.
- Apex Therapy Services (and legal counsel or other consultants) will meet with the governing body of Apex Therapy Services and present a report on their investigation, which will include findings and recommendations of actions.
- Apex Therapy Services will meet with the alleged perpetrator and notify him/her/them of the results of the investigation and recommendations for actions.
- Apex Therapy Services will meet with the alleged victim, along with his/her/their parent(s)/guardian(s) and notify them of the results of the investigation and recommendations for actions.
- During the investigation, Apex Therapy Services shall maintain contact with the alleged victim and his/her/their Parent/Guardian and inform them of the actions taken and assist them in their process of healing.

- Apex Therapy Services (and legal counsel or other consultants) may meet with the alleged perpetrator, the alleged victim, and any others with knowledge of relevant facts.
- Communicate with criminal and civil legal counsel of Apex Therapy Services.
- Communicate with those affected by the alleged perpetrator.
- Hire a consultant or assign a spokesperson to respond to media or prepare a statement for the media if the need shall arise, client to the approval of Apex Therapy Services' attorney.

Abuse and Molestation Prevention Policy Acknowledgement

These guidelines have been designed to guide and assist you when working with minors. The information establishes general practices and guidelines and should not be construed in any way as a contract of employment or continued employment. Apex Therapy Services reserves the right to make changes in the content or application of this program and to implement those changes with or without notice.

The terms defined herein are defined for the purposes of the program and do not suppose or establish a legal relationship. These terms are not defined for the purposes of creating a legal relationship with the Apex Therapy Services or any related or associated entity and instead are to be used with this document.

I have received a copy of the Apex Therapy Services' Abuse and Molestation Prevention Policy. I understand it is my responsibility to become familiar with and adhere to the information contained herein. I understand that these policies are the property of the Apex Therapy Services.

Client Name: _____

Client Signature: _____

Date: _____

Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____



HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: 3/1/2024

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

If you have any questions or need assistance regarding this notice, please contact the Apex Therapy Services Privacy Officer at:

Phone: 248-712-1129

E-mail: nanci@kamoophd.com

Mail: Apex Therapy Services

Attention: Privacy Officer

30200 Telegraph Road, Suite 207

Bingham Farms, Michigan 48025

WHO WILL FOLLOW THIS NOTICE:

The terms of this Notice of Privacy Practices (“Notice”) applies to Apex Therapy Services, its affiliates, and any director, officer, employee, agent, advisor, staff member, subcontractor, consultant, volunteer, or any other person acting for or on behalf of Apex Therapy Services (collectively referred to as “Agency Representatives”). Apex Therapy Services will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

OUR OBLIGATIONS:

We are mandated by law to safeguard the privacy of our patients' protected health information and to provide patients with a notice outlining our legal duties and privacy practices with respect to protected health information (PHI). We are required to abide by the terms of this Notice for as long as it remains in effect. . We retain the right to modify the terms of this Notice as needed and to implement a new notice of privacy practices applicable to all PHI maintained by Apex Therapy Services. Additionally, we are required to inform you that there may exist state laws governing the privacy of your health information that are more stringent than those outlined in the Federal Health Insurance Portability and Accountability Act ("HIPAA"). Requests for a copy of any revised Notice of Privacy Practices or information pertaining to specific state laws can be made by mailing a request to the Privacy Officer at the address provided on page 1.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION (PHI):

Below are some examples demonstrating different ways we are authorized to use and disclose health information that identifies you (PHI). Michigan law may require that we obtain your explicit permission for certain health information to be used or disclosed, such as in cases involving behavioral health, substance abuse, or HIV/AIDS information.

Authorization and Consent: Except as described below, we will not use or share your PHI for any reason other than treatment, payment, or healthcare operations, unless you have signed a form authorizing such use or disclosure. You have the ability to take back, or revoke," your written authorization, and the revocation will take effect once we have received the writing. If you cancel your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Uses and Disclosures for Treatment: We will use and share your PHI as needed for your treatment and to provide you with treatment-related health care services and/or products. For example, we might share your PHI with nurses, technicians, or other staff members involved in your medical care, both within and outside our office. They will need this information to give you proper medical care. We may also make your PHI available electronically through one or more health information exchanges or organizations (“HIOs”) to other health care providers, health plans or health care clearinghouses. Our participation in HIOs helps us care for you.

Uses and Disclosures for Payment: We might use and share PHI to bill and receive payment from you, your insurance company, or a third party for the treatment and services you've received. For instance, we may provide your health plan with details about you so they can cover the cost of your treatment. We may also use your information to prepare a bill to send to you or to the person responsible for your payment

Uses and Disclosures for Health Care Operations: We may use and disclose your PHI, as necessary, and as permitted by law, for the purpose of health care operations. These uses and disclosures are essential to ensure that all our patients receive high-quality care and to effectively run and oversee our organization. For instance, we might use and share information to ensure the treatment you receive meets the highest standards. Other reasons for PHI use and disclosure may include clinical improvement, professional peer review, business management, and licensing and accreditation. Additionally, we may exchange information with other entities, such as your health plan, for their healthcare operation activities. Sharing your health information through HIOs, as mentioned earlier, may also be part of our healthcare operations.

Individuals Involved In Your Care: At times, we may disclose your PHI to selected family, friends, or others involved in your care or payment for your care, to facilitate their involvement in assisting you or covering your expenses. If you are unavailable, incapacitated,

or facing a medical emergency, and we believe it is in your best interest, we may share limited PHI with these individuals without seeking your approval. Additionally, we may share limited PHI with authorized public or private entities involved in disaster relief efforts to help locate family members or others involved in your care. Under Michigan law, we would only disclose PHI related to a minor's treatment for venereal disease and HIV testing, substance abuse, behavioral health, and prenatal/pregnancy treatment for specific medical reasons.

Business Associates: Some aspects of our services involve working with external individuals or organizations through contracts, such as registration, billing, auditing, accreditation, outcomes data collection, and legal services. There may be occasions when we need to share your PHI with these external individuals or organizations to support our healthcare operations. All of our business associates are required to safeguard the privacy of your information and are prohibited from using or disclosing any information beyond what is outlined in our contract.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services:

We may use and disclose PHI when contacting you to remind you about upcoming appointments with your provider, to provide you with appointment updates, or to provide you with information regarding your treatment, potential alternative treatment options, or health-related benefits and services that could be beneficial to you. You have the right to request, and we will honor reasonable requests from you to receive communications about your PHI from us through alternative methods or at different locations. For example, if you prefer not to receive appointment reminders via voicemail or to a specific address, we will honor reasonable requests. You must provide an appropriate alternative address or contact method with such a request. Additionally, you can ask us not to send you any future marketing materials, and we will do our best to comply with your request. Please make such requests in writing, including your name and address, and send them to the Privacy Officer at the address provided on page 1.

Research: In certain situations, we may utilize and share your PHI for research purposes. For instance, a research study might involve comparing the health outcomes of patients who underwent different treatments for the same condition. In situations where your specific authorization is not obtained, your privacy will be safeguarded by stringent confidentiality requirements enforced by an Institutional Review Board overseeing the research, or by assurances from the researchers themselves limiting the use and disclosure of your information. We may also allow researchers to access records to help identify potential participants for their research project or for similar purposes, provided they do not remove or take a copy of any PHI.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, and for required public health investigations;
- If we suspect child abuse or neglect;
- If we believe you to be a victim of abuse, neglect, or domestic violence;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To prevent a serious threat to your health, safety, or that of the public or another individual. However, disclosures will only be made to individuals who could assist in preventing the threat.

- To a health oversight agency for activities permitted by law. These oversight activities include, for example, audits, investigations, inspections, and licensure, which are essential for the government to oversee the healthcare system, government programs, and adherence to civil rights laws.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To comply with any laws related to workers' compensation or similar programs.
- To your employer when health care was provided to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- If you are incarcerated in a correctional facility or under the supervision of law enforcement, we may disclose Health Information to the correctional institution or law enforcement personnel. This disclosure would occur if necessary:
 1. For the institution to administer healthcare to you;
 2. To safeguard your health and safety or that of others; or
 3. To maintain the safety and security of the correctional facility.
- To coroners and/or funeral directors consistent with law;
- If necessary, to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your PHI for national security or intelligence activities;

- To disaster relief organizations that require your PHI to coordinate your care or inform your family and friends about your location or condition during a disaster. Whenever possible, we will offer you the chance to consent or dissent to such a disclosure; and
- To provide legally required notices of any unauthorized access or disclosure of your PHI.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization before disclosing any psychotherapy notes, unless permitted otherwise by law. However, there are certain circumstances in which we may disclose psychotherapy notes without your written authorization, including:

1. To carry out certain treatment, payment, or healthcare operations, such as for your treatment, for internal training purposes, and/or defending ourselves in legal actions brought by you;
2. To the Secretary of the Department of Health and Human Services to ensure compliance with the law;
3. As required by law;
4. For health oversight activities authorized by law;
5. To medical examiners or coroners as permitted by state law; or
6. For the purpose of preventing or reducing a serious or imminent threat to the health or safety of an individual or the public.

Genetic Information: Before using or disclosing your genetic information for treatment, payment, or healthcare operations, we are required to obtain your specific written authorization. However, we may utilize or disclose your genetic information without your written authorization only when permitted by law.

Marketing: We are required to obtain your authorization for any use or disclosure of your protected health information for marketing purposes, except in the case of:

1. Face-to-face communication with you, or
2. A promotional gift of nominal value.

Sale of Protected Information: We need your authorization before accepting direct or indirect remuneration (“payment”) in exchange for your health information. However, authorization is not necessary when the purpose of the exchange is for:

- Public health activities;
- For research purposes, as long as we receive only a reasonable, cost-based fee to cover the expenses of preparing and transmitting the information.
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we offer to a business associate for tasks involving the exchange of PHI, which the business associate carries out on our behalf (or a subcontractor carries out on behalf of a business associate), where the sole payment is for the completion of these tasks;
- Providing you with a copy of your health information or a record of disclosures;
- Disclosures required by law;
- Sharing your health information for any other permissible purpose under the Privacy Rule of HIPAA, provided that the only compensation we receive is a reasonable, cost-based fee for the preparation and transmission of your health information for that purpose, or a fee explicitly allowed by other law; or

- Any other exceptions permitted by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PHI:

You have the following rights regarding the PHI we have about you. To exercise these rights, you must submit a written request to the Privacy Officer at the address provided on page 1 of this document.

Access to your PHI: You have the right to review and obtain a copy of your Health Information, which is used for decisions about your care or payment. This includes medical and billing records, excluding psychotherapy notes or information for legal proceedings. Access requests must be submitted in writing and signed by you or your legal representative. We have a maximum of 30 days to provide your PHI. A reasonable fee for copying, postage, and supply costs will be charged for providing your protected health information. Additional charges will apply for extra copies and postage if requested. No fee will be charged if you require the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. In certain circumstances, we may deny your request. If denied, you have the right to appeal to a licensed healthcare professional not involved in the initial denial, and we will comply with the review outcome.

If your PHI is stored electronically (in an electronic medical record or electronic health record), you can request an electronic copy of your record to be provided to you or sent to another individual or entity. We will make every effort to accommodate your preferred form or format for accessing your PHI, if it is easily available in that form or format. If not, your record will be provided in our standard electronic format or, if preferred, as a readable hard copy. A reasonable, cost-based fee may be charged, as permitted by law, for the labor involved in transmitting the electronic medical record.

Amendments to your PHI: If you believe that any of the PHI we maintain about you is inaccurate or incomplete, you have the right to request an amendment or correction. You retain the right to request an amendment for as long as the information is kept by or for our office. While we are not required to make requested changes, we will carefully review each request. All requests for amendments must be in writing, signed by you or your legal representative, and must include the reasons for the request. If an amendment or correction is requested, we may inform relevant parties if we believe it is necessary.

Accounting for Disclosures of your PHI: You have the right to ask for a record of certain disclosures we made regarding your PHI. Your request for this list of disclosures should specify a time frame not exceeding six (6) years from your request date and must not include dates prior to April 14, 2003. Additionally, please indicate your preferred format for the list (e.g., paper, electronic). The initial list requested within a twelve (12) month period will be provided to you at no cost. However, for subsequent lists, there may be a charge to cover the expenses of providing the information. We will inform you of any associated costs, allowing you to amend (change) or withdraw (cancel) your request before incurring any charges.

Restrictions on the Use and Disclosure of your PHI: You have the right to request limitations on the use and disclosure of your PHI for treatment, payment, or health care operations. While we are not obligated to accept most restriction requests, we strive to accommodate reasonable ones when suitable. You also have the option to request restrictions on disclosing PHI to individuals involved in your care or payment, such as family members or friends. For instance, you may request that we refrain from sharing specific diagnosis or treatment details with your spouse. While we are not obligated to accept your request, if we do agree, we will comply with it unless the information is essential for providing emergency treatment.

Additionally, you have the right to restrict the disclosure of your PHI to a health plan if it pertains solely to a health care item or service that you, or someone else on your behalf, have paid Apex Therapy Services for in full, and if the disclosure is for payment or health care

operations purposes and is not mandated by law. If we accept discretionary restrictions, we maintain the right to remove them as necessary, and we will inform you if any such removal occurs. Additionally, you may withdraw any restriction, either in writing or orally, by communicating your decision to the individual in charge of medical records.

Notice of Breach: We prioritize the confidentiality of our patients' information and adhere to all legal requirements and proper measures to safeguard the privacy and security of your PHI. If a breach involving or potentially involving your unsecured health information occurs, we will promptly notify you and provide guidance on steps you may need to take to protect yourself.

Out-Of-Pocket-Payments: In the event that you have decided to pay for in full for a specific item or service and requested that we not bill your health plan, you can request that your PHI related to this item or service not be shared with your health plan for payment or health care operations purposes. We will honor this request unless prohibited by law.

Requesting Confidential Communications: You have the right to request that we communicate with you regarding your PHI in a specific method and/or location. For instance, you may request that we only contact you via mail or at your workplace. Your request should detail your preferred method or location. We will accommodate reasonable requests.

Paper Copy of this Notice: Even if you've consented to receive notices electronically, you still have the right to receive a paper copy of this Notice. To request a paper copy of this Notice, please contact the Privacy Officer at the address provided on page 1 of this document.

CHANGES TO THIS NOTICE:

We retain the right to modify this notice and have the new notice apply to current PHI as well as any PHI we receive in the future. A copy of the current notice will be displayed at our office, with the effective date indicated on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office by contacting the Privacy Officer using the information provided on page 1 of this document. You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. All complaints must be made in writing. You will not be penalized or face retaliation for filing a complaint.

Notice of Privacy Practices Receipt Form

I, _____, have read and received a copy of the Notice of Privacy Practices from an Agency Representative of Apex Therapy Services.

Client Name: _____

Signature: _____

Date: _____

Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____

Agreement to Videotape - Audiotape - Photograph

Adult Client

Agency Representatives of Apex Therapy Services Agency Representatives may take photographs or videotapes solely for the purpose of in-house (within the agency) education, training, or observation purposes. I acknowledge that I may be photographed or videotaped during a session only if it is of value to my treatment or programming. Agency Representatives may, at times, use agency-issued devices to record sessions as a method of reviewing my treatment and progress as well as to assess the performance and Agency Representatives.

I give Apex Therapy Services permission to take and/or use photos or videos of me for programming or training purposes only. Videos and pictures will ONLY be taken with Apex Therapy Services equipment and will not be shared or used for marketing purposes. I may withdraw my consent at any time. Apex Therapy Services Agency Representatives are not allowed to record any videos, pictures, or audio using his, her, or their personal equipment.

Unless otherwise permitted by law, Apex Therapy Services does not permit the client, client's parent(s)/guardian(s) or any other non-Agency Representatives to photograph, audiotape, or videotape service delivery. If security cameras/closed-circuit television are installed, they must be turned off/disabled during service delivery. Furthermore, Agency Representatives do not consent to being videotaped, photographed, or audiotaped by non-Agency Representatives.

Permission to Photograph, Videotape, or Audiotape:

- I do not give permission to photograph, videotape, or audiotape
- I give permission and consent for Apex Therapy Services to photograph myself during the time I am enrolled in services. I understand these photographs may be used in educational presentations.
- I give permission for Apex Therapy Services to take and use video/pictures of me during my session only.
- I give permission for Apex Therapy Services to use full-face photographs of me for instructional purposes only.
- I give permission and consent for Apex Therapy Services to videotape and audio tape myself during the time I am enrolled in services. I understand these files will not be used outside the company and will be kept confidential. I understand that the audio/video files will be used for the purpose of developing more effective educational and therapeutic plans for my treatment and also for the purposes of education and training for Apex Therapy Services.
- I give permission for Apex Therapy Services to use recorded video segments to present for conferences and other training purposes.

Client Name: _____

Client Signature: _____

Date: _____

Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____

Authorization and Consent to Participate in Telehealth Consultation

The purpose of this form is to obtain your consent to participate in a telehealth consultation with **Apex Therapy Services**.

1. **Purpose and Benefits.** The purpose of the tele-health consultation is to enable clients living in rural and/or underserved areas to get medical care by specialists without the inconvenience and expense of traveling to a city.
2. **Nature of Telemedicine Consultation.** During the tele-health consultation:
 - a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive visual and audio aids, and other technology.
 - b. Physical examination of client may occur.
 - c. The presence of non-medical and/or technical personnel in the telemedicine studio solely for the purpose of technology assistance.
 - d. Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
3. **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this tele-health consultation. Additionally, distribution of any client identifiable content, images, or information from the telemedicine session to researchers or other pre-determined affiliates will not occur without your prior expressed consent, unless authorized under existing confidentiality laws.

4. **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Michigan state law apply to information disclosed during this telemedicine consultation.

5. **Risks and Consequences.** The tele-health consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct client to physician contact. Following the tele-health consultation, your physician may recommend a visit to a local hospital or medical facility for further evaluation.

6. **Rights.** You may withdraw consent for any tele-health or telemedicine session or consultation at any time without impact on your right to future care or treatment, or without risking withdrawal from program benefits to which you would otherwise be entitled. You have the option to consult with the specialist in person if you travel to his or her location.

I have been advised of all the potential benefits, risks, and consequences of the tele-health and telemedicine sessions. My health care practitioner has shared all the information provided above. I have had opportunities to ask questions about the tele-health and telemedicine sessions and have received answers to any questions that have been posed. I understand the written information provided above.

Client Name: _____

Client Signature: _____

Date: _____

Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____

Apex Therapy Services

RELEASE OF INFORMATION

Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

Account Number: _____

SSN: _____

Phone Number: _____

1. I authorize the use or release of the above named individual's health information as described below is authorized to release information: _____

Address: _____

2. The type and amount of information to be used or released is as follows: (check those that apply and include dates where appropriate)

- Checkboxes for School Observation, Discharge Summary, History and Assessment, Consultation, All Consultations, Billing Information, Home Health Record, Entire Record, and Other.

3. I understand that the information in my health record may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be released to and used by the following individual or organization:

Address: _____

For the purpose of: _____

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Apex Therapy Services. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

6. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand I may inspect or copy the information to be used or released, as provided in 45 C.F.R. 164.524. I understand any release of information carries with it the potential for re-release by the recipient and once authorized to be released, the information may not be protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Legal Representative _____

Date _____

If Signed by Legal Representative, Relationship to Patient _____

Printed Name of Witness #1 _____

Signature of Witness #1 _____

Date _____

Printed Name of Witness #2 _____

Signature of Witness #2 _____

Date _____

THIS RELEASE MUST BE SIGNED BY AT LEAST ONE WITNESS. TWO WITNESSES ARE REQUIRED IF THIS STATEMENT HAS BEEN SIGNED

Agency Representative Descriptions

**An Agency Representative is defined as any director, officer, employee, agent, advisor, staff member, subcontractor, consultant, volunteer, or any other person acting for or on behalf of Apex Therapy Services.*

Clinic Director of Apex Therapy Services:

The Clinic Director oversees all directors and administrative representatives within Apex Therapy Services, ensuring the creation and implementation of company-wide policies and procedures.

Autism Services Program Director:

The Apex Therapy Autism Services Program Director is responsible for overseeing the development, implementation, and evaluation of services designed to meet the needs of individuals with Autism Spectrum Disorder and their family members. The Program Director also oversees the Autism Services Program Agency Representatives and assists with the design and development of clinical operations.

ABA Supervisor:

Each client receiving ABA services is assigned an ABA Supervisor, who acts as the primary contact for the client. The ABA Supervisor designs, implements, and oversees individualized behavioral support services, provides guidance to ABA Behavior Technicians and caregivers, develops comprehensive treatment plans, and provides parent/guardian training. ABA Supervisors also collaborate with other service providers and regularly supervise and evaluate ABA Behavior Technicians through providing written and verbal feedback.

Lead ABA Technician:

Lead ABA Technicians provide guidance and support to fellow ABA Technicians to ensure the effective implementation of treatment plans and Behavior Intervention Plans (BIPs). They also assist the Autism Services Program Director and ABA Supervisors with tasks such as new hire training, monitoring treatment integrity, offering follow-up training, and other advanced responsibilities focused on upholding the highest standard of care for individuals enrolled in the Autism Services Program.

ABA Technician:

ABA Technicians are primarily responsible for implementing individualized treatment plans developed by an ABA Supervisor, collecting data to record and monitor progress, and working closely with the client's ABA Supervisor to update the treatment plan or programming as needed. The ABA Behavior Technician is directly supervised by an ABA Supervisor and communicates with them regularly regarding client progress.

The entire ABA Therapy team works together to make sure that the client is receiving the best possible services based on his/her/their individual goals. Duties and responsibilities of team members may vary and are not limited to the roles as stated above.

There is no guarantee that the same ABA Technician, Lead ABA Technician, or ABA Supervisor will be assigned to a client's case for the entire time they receive services at Apex Therapy Services, as we encourage staff changes from time to time to facilitate generalization of skills across multiple clinicians. Apex Therapy Services will let you know in advance of any upcoming team changes, whenever possible.

I acknowledge that my therapist team may change at any time.

Client Name: _____

Client Signature: _____

Date: _____

Agency Representative Name: _____

Agency Representative Signature: _____

Date: _____

ADULT MEDICAL HISTORY QUESTIONNAIRE

Client Name:	Age:	
Form Completed by:	Relationship to Client:	
Medical History		
Do you have allergies? <i>If yes, please describe:</i> _____ Are they life threatening?	__ Yes	__ No
Are you currently being treated for any chronic health problems? <i>If yes, please describe:</i> _____	__ Yes	__ No
<i>Have you...</i>		
• Ever been hospitalized? (non-surgical) <i>If yes, please describe:</i> _____	__ Yes	__ No
• Ever had surgery? <i>If yes, please describe:</i> _____	__ Yes	__ No
• Ever required medical treatment at an Emergency Room/Hospital? <i>If yes, please describe:</i> _____	__ Yes	__ No
Do you have any diet restrictions or special dietary needs? <i>If yes, please describe:</i> _____	__ Yes	__ No

Birth History		
<i>Were you...</i>		
• Born on time?	__ Yes	__ No
• Born after your due date?	__ Yes	__ No
• Born early (not premature)?	__ Yes	__ No
• Born prematurely?	__ Yes	__ No
• Born by cesarean section (C-Section)?	__ Yes	__ No
Did your mother experience any pregnancy complications? <i>If yes, please describe:</i> _____	__ Yes	__ No
Did your mother experience any labor and/or delivery complications? <i>If yes, please describe:</i> _____	__ Yes	__ No

Did you require time in the NICU after birth? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you or your mother experience any other pregnancy or birth complications that we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Health Review

<i>Do you regularly experience any of the following GENERAL symptoms?</i>		
• Nose/sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Skin problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Throat problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Eye problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Head problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Ear problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Lungs/Breathing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Gastrointestinal (GI) problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Nervous System/Neurological (brain) Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Heart problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Urinary tract problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Blood or metabolic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Do you regularly experience any of the following EAR symptoms?</i>		
• Itching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Fullness/Popping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Hearing problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your hearing been tested before? <i>If yes, what were the results?</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other ear-related symptoms we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Do you regularly experience any of the following THROAT symptoms?</i>		
• Itching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Post-nasal drip	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Bad breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Soreness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Throat Clearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Tonsillitis/Strep throat/Throat infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other throat-related symptoms we should be aware of? <i>If yes, please describe: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Do you regularly experience any of the following PULMONARY/RESPIRATORY symptoms?</i>		
• Frequent/chronic cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Sputum (mucus) production	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Chest tightness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Bloody/blood streaked sputum (mucus)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Chronic bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other lung/breathing related symptoms we should know about? <i>If yes, please describe: _____</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Do you regularly experience any of the following EYE symptoms?</i>		
• Itching/burning	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Frequent tearing/discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Redness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Eyelid irritation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Pain when exposed to bright light.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Farsightedness (difficulty seeing up close)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Myopia (difficulty seeing far distances)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Any other eye-related symptoms we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<i>Do you regularly experience any of the following SKIN symptoms?</i>		
• Rashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Itching (skin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Swelling (skin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other skin-related symptoms we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Do you regularly experience any of the following GASTROINTESTINAL (GI) symptoms?</i>		
• Frequent nausea/vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Heartburn/acid reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other gastrointestinal (GI) related symptoms we should know about? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Do you regularly experience any of the following HEAD/NEUROLOGICAL symptoms?</i>		
• Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• History of concussion, head trauma, or brain injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Weakness/clumsiness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Tingling/burning	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Delayed development	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other head-related or neurological symptoms we should be aware of? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<i>Do you regularly experience any of the following URINARY TRACT symptoms?</i>		
• History of frequent bladder or urinary tract infections	__Yes	__No
• Frequent urination	__Yes	__No
• Trouble starting urine	__Yes	__No
Any other urinary tract-related symptoms that we should be aware of? <i>If yes, please describe:</i> _____	__Yes	__No

Mental health		
<i>Have you ever been diagnosed with or struggled with symptoms of...</i>		
• Autism Spectrum Disorder (ASD)	__Yes	__No
• Attention Deficit/Hyperactivity disorder (AD/HD)	__Yes	__No
• Obsessive-Compulsive Disorder (OCD)	__Yes	__No
• Learning Disability	__Yes	__No
• Global Developmental Delay	__Yes	__No
• Intellectual Disability/Cognitive Impairment	__Yes	__No
• Anxiety	__Yes	__No
• Depression	__Yes	__No
• Bipolar Disorder	__Yes	__No
• Sleeping issues	__Yes	__No
• Feeding or eating issues	__Yes	__No
Any other mental health symptoms or diagnosed conditions that we should be aware of? <i>If yes, please describe:</i> _____	__Yes	__No

Medications and Immunizations		
<i>Do you regularly take...</i>		
<ul style="list-style-type: none"> • Prescription medication? <i>If yes, which medication(s)? Include name(s) and dosage: _____</i> 	__Yes	__No
<ul style="list-style-type: none"> • Over-the-counter medications? <i>If yes, which medication(s)? Include name(s) and dosage: _____</i> 	__Yes	__No
<ul style="list-style-type: none"> • Vitamins/supplements? <i>If yes, please provide a list of vitamins/supplements, including name and dosage. _____</i> 	__Yes	__No
Are your immunizations up to date? <i>If not, explain why: _____</i>	__Yes	__No

Family Medical History		
<i>Do any of the following conditions run in your family?</i>		
• Nose/Sinus problems	__Yes	__No
• Skin problems	__Yes	__No
• Throat problems	__Yes	__No
• Eye problems	__Yes	__No
• Head problems	__Yes	__No
• Ear problems	__Yes	__No
• Lungs/Breathing Problems	__Yes	__No
• Gastrointestinal (GI) problems	__Yes	__No
• Muscle/bone problems	__Yes	__No
• Nervous System/Neurological (Brain) problems	__Yes	__No
• Heart problems	__Yes	__No
• Urinary tract problems	__Yes	__No
• Blood or metabolic problems	__Yes	__No
Any other conditions we should know about? <i>If yes, please describe: _____</i>	__Yes	__No

Family Mental Health History		
<i>Do any of the following conditions run in your family?</i>		
• Autism Spectrum Disorder (ASD)	__Yes	__No
• Attention Deficit/Hyperactivity Disorder (AD/HD)	__Yes	__No
• Obsessive-Compulsive Disorder (OCD)	__Yes	__No
• Learning Disability	__Yes	__No
• Global Developmental Delay	__Yes	__No
• Intellectual Disability/Cognitive Impairment	__Yes	__No
• Anxiety	__Yes	__No
• Depression	__Yes	__No
• Bipolar Disorder	__Yes	__No
• Sleeping issues	__Yes	__No
• Feeding or eating issues	__Yes	__No
Any other mental health symptoms or diagnosed conditions that run in your family? <i>If yes, please list:</i> _____	__Yes	__No

Client Questionnaire

To be filled out by adult/adolescent client

Client's Name: _____

Instructions:

*Please provide the following information as part of your ABA Skills Assessment. **Please answer each question to the best of your ability.** If you encounter any questions that are unclear or require assistance, please mark an X in the margin next to that question. Your clinician will review your responses with you during the ABA Skills Assessment and may ask follow-up questions to gain a better understanding of your needs.*

Family Information:

Parent/Guardian Name:	
Relationship to Client:	<input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Adoptive <input type="checkbox"/> Step <input type="checkbox"/> Caregiver <input type="checkbox"/> Other: _____
Home Phone:	
Cell Phone:	
Work Phone:	
Email:	
Parent/Guardian Name:	
Relationship to Client:	<input type="checkbox"/> Biological <input type="checkbox"/> Foster <input type="checkbox"/> Adoptive <input type="checkbox"/> Step <input type="checkbox"/> Caregiver <input type="checkbox"/> Other: _____
Home Phone:	
Cell Phone:	
Work Phone:	
Email:	

For adolescent clients aged 17 and younger:

Are your parents divorced, separated, or not married? YES NO

*If yes**

- Who is legally responsible for making medical decisions on your behalf? Joint Sole
 - If sole custody, please specify which parent:
- Are both parents in agreement about ABA services being sought through Apex Therapy Services? YES NO

If no, please explain:

- Please describe your current living arrangement, including visitation schedule (if applicable):

*** Please provide a copy of any formal custody arrangements or related legal documentation to your first appointment**

Do you have any siblings? ___ YES ___ NO *If yes, please provide information below:*

Name of Sibling	Date of Birth	Age	Gender	Relationship to You
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____
				__ Biological __ Foster __ Adoptive __ Half __ Step __ Other: _____

Does anyone else live in your home? ___ YES ___ NO *If yes, please provide information below:*

Name of Individual	Age	Gender	Relationship to You

Which language is primarily spoken within your home? __ English __ Other (specify): _____

- **Approximately what percent of the time are you exposed to non-English languages?** _____ %
- **Do you require or would like to request an interpreter?** ___ YES ___ NO

Please describe any cultural and/or spiritual practices, rituals, traditions, or beliefs that you feel are important for us to understand before working with you.

Are there any legal issues that may impact your treatment? ___ YES ___ NO

If yes, please describe:*

--

** Please provide a copy of any relevant legal documents with you to your first appointment.*

Emergency Contact Information:

Name	
Relationship to You	
Home Phone	
Cell Phone	
Work Phone	
Email Address	

Name	
Relationship to You	
Home Phone	
Cell Phone	
Work Phone	
Email Address	

Hours of Availability

*Please mark the times you are available for **1:1 ABA therapy**:*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 AM							
8:30 AM							
9:00 AM							
9:30 AM							
10:00 AM							
10:30 AM							
11:00 AM							
11:30 AM							
12:00 PM							
12:30 PM							
1:00 PM							
1:30 PM							
2:00 PM							
2:30 PM							
3:00 PM							
3:30 PM							
4:00 PM							
4:30 PM							
5:00 PM							
5:30 PM							
6:00 PM							
6:30 PM							
7:00 PM							
7:30 PM							

If applicable: Please mark the times your family is available for **Family/Caregiver meetings:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 AM							
8:30 AM							
9:00 AM							
9:30 AM							
10:00 AM							
10:30 AM							
11:00 AM							
11:30 AM							
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4:30 PM							
5:00 PM							
5:30 PM							
6:00 PM							
6:30 PM							
7:00 PM							
7:30 PM							

Previous Evaluations/Assessments:

Have you ever been assessed/evaluated by an Occupational Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other professional? ___ YES ___ NO

If yes, please provide the following information:*

Name	
Type of Specialist	
Date of Evaluation	
Reason for Evaluation/Services	
Evaluation Results	

Name	
Type of Specialist	
Date of Evaluation	
Reason for Evaluation/Services	
Evaluation Results	

Name	
Type of Specialist	
Date of Evaluation	
Reason for Evaluation/Services	
Evaluation Results	

**Please provide a copy of any previous evaluations/assessments with you to your first appointment.*

Treatment History

Have you previously received ABA therapy? YES NO

If yes:

Name of Agency/Center			
Dates Attended	From _____ until _____		
Average Number of Hours Per Week			
ABA Therapy Location (mark all that apply)	<input type="checkbox"/> Home-based <input type="checkbox"/> Clinic-based <input type="checkbox"/> Community-based		
If you recall, what were names of the BCBA(s)/ABA Supervisor(s) who oversaw your treatment?			
Did your BCBA/ABA supervisor offer parent/family training?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes – how often did your family meet 1:1 with your ABA supervisor?	_____ times per month		
Overall, how satisfied were you with your treatment?	Very satisfied	Satisfied	Neither satisfied nor dissatisfied
	Dissatisfied	Very dissatisfied	
Any other information that you would like us to know?			

Name of Agency/Center			
Dates Attended	From _____ until _____		
Average Number of Hours Per Week			
ABA Therapy Location (mark all that apply)	<input type="checkbox"/> Home-based <input type="checkbox"/> Clinic-based <input type="checkbox"/> Community-based		
If you recall, what were names of the BCBA(s)/ABA Supervisor(s) who oversaw your treatment?			
Did your BCBA/ABA supervisor offer parent/family training?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes – how often did your family meet 1:1 with your ABA supervisor?	_____ times per month		
Overall, how satisfied were you with your treatment?	Very satisfied	Satisfied	Neither satisfied nor dissatisfied
	Dissatisfied	Very dissatisfied	
Any other information that you would like us to know?			

**Please provide any information you have regarding your prior ABA program(s) with you to your first appointment.*

Do you currently receive any other therapies (outside of school)? YES NO

If yes, which therapies?

- Speech Therapy
 Occupational Therapy
 Physical Therapy
 Psychotherapy
 Other (list): _____

Educational History:

Are you currently enrolled in school?* YES NO

** Mark YES if you attend school but are currently on break (e.g., winter, spring, or summer recess).*

If yes, please provide information below:

School Name	
School Address	
School Contact Information	Phone: Email:
Teacher's Name:	
Grade	
Type of Classroom:	
Therapies/Supports Provided at School	<input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Social Work <input type="checkbox"/> Resource Room <input type="checkbox"/> Other: _____

Do you currently have an Individualized Education Plan (IEP) or 504 Plan*? YES NO

**If yes, please bring a copy of your current IEP or 504 Plan with you to your first appointment.*

Did you have an Individualized Education Plan (IEP) or 504 Plan when younger? YES NO

What kind of programs or schools have you attended in the past?

School/Program Name	Type of Program	Dates Attended	Therapies/Supports Provided
		From _____ to _____	

Developmental Milestones and History:

Please fill out the following table regarding your early development:

Developmental Milestone	Has Milestone been Met?	Approximate Age when First Occurred
Independent walking	__ YES __ NO	__ years __ months
Speaking in single words	__ YES __ NO	__ years __ months
Speaking in 2 word phrases	__ YES __ NO	__ years __ months
Speaking in 3 word sentences	__ YES __ NO	__ years __ months
Daytime Toilet Trained – Urine	__ YES __ NO	__ years __ months
Daytime Toilet Trained – Bowel	__ YES __ NO	__ years __ months
Nighttime Toilet Trained – Urine	__ YES __ NO	__ years __ months
Nighttime Toilet Trained – Bowel	__ YES __ NO	__ years __ months

At what age were your parents/caregivers first concerned about your development or behavior?

__ years __ months

What did they notice?

Did you lose language skills during your early years or experienced a period where you stopped speaking for several months after you had begun talking? __ YES __ NO

If yes:

- **How old were you when you first began to lose language skills? __ years __ months**
- **How much language did you have before you began to lose it?**

- **Have you regained the language that you previously lost? __ YES __ NO**
 - **If yes, at what age did your language begin to return? __ years __ months**

Did you ever lose any other skills that you previously had? __ YES __ NO

If yes:

- **What skill(s) did you lose?**

- **Have you regained the skill(s) that you previously lost? __ YES __ NO**
 - **If yes, at what age did the skill(s) begin to return? __ years __ months**

Current Strengths and Areas of Need:

Please indicate anything that your ABA team should know about when working with you.

Preferences/Interests:

Favorite Activities:
Favorite Foods/Drinks:
Favorite Interests/Topics:
Any other favorites:

Dislikes/Aversions:

--

What types of foods do you generally eat?

--

What types of foods do you avoid?

--

Any other important information:

--

What are your top five (5) strengths?

1)
2)
3)
4)
5)

What are the top five (5) activities you like to do with others?

“Activities” can include any time spent with others - not just formal/structured time.

1)
2)
3)
4)
5)

How do you communicate with others? (select all that apply)

<i>Vocalizations/Spoken Language</i>			
<input type="checkbox"/> Single words	<input type="checkbox"/> Phrase speech	<input type="checkbox"/> Sentences	<input type="checkbox"/> Non-word sounds/noises

<i>Sign Language</i>		
<input type="checkbox"/> Single words	<input type="checkbox"/> Phrase speech	<input type="checkbox"/> Sentences

<i>Alternative and Augmentative Communication (AAC) Device</i>		
<input type="checkbox"/> Picture Board/Core Board	<input type="checkbox"/> PECS book/Picture Exchange	<input type="checkbox"/> Electronic AAC device
<input type="checkbox"/> Other: _____		

<i>Non-Verbal Behavior</i>			
<input type="checkbox"/> Point to desired items	<input type="checkbox"/> Nod/Shake head	<input type="checkbox"/> Gestures	<input type="checkbox"/> Facial Expressions/Body Language
<input type="checkbox"/> Use someone’s hand/arm as a tool (e.g. Places hand on refrigerator door to request food/drink, Places hand on doorknob to request to go outside)			
<input type="checkbox"/> Other: _____			

Please describe/explain your primary reason for seeking ABA services:

Do you have any concerns regarding your:

Cognitive Functioning/Learning ___ YES ___ NO	<i>If yes, describe/explain:</i>
Motor Skills ___ YES ___ NO	<i>If yes, describe/explain</i>
Behavior ___ YES ___ NO	<i>If yes, describe/explain</i>
Language/Communication ___ YES ___ NO	<i>If yes, describe/explain</i>
Social Skills ___ YES ___ NO	<i>If yes, describe/explain</i>
Peer Interactions ___ YES ___ NO	<i>If yes, describe/explain</i>
Play and Leisure Skills ___ YES ___ NO	<i>If yes, describe/explain</i>
Self-Help Skills/Activities of Daily Living (dressing, toileting, feeding, etc.) ___ YES ___ NO	<i>If yes, describe/explain</i>

Please list the top five (5) areas or goals you would like to work on in ABA therapy over the next six (6) months of treatment:

1)
2)
3)
4)
5)

Risk Assessment

Client Name: _____

Date of Birth: _____

Agency Representative Name: _____

Date: _____

INSTRUCTIONS: Please answer each question to the best of your ability. Check "no" if a question doesn't apply to you.

Abuse and Neglect

Have you ever...

- Experienced physical abuse? __Yes __No
- Experienced sexual abuse? __Yes __No
- Been subjected to emotional or verbal abuse? __Yes __No
- Been exposed to domestic violence? __Yes __No
- Been exposed to excessive violence in the community? __Yes __No

Treatment, Services & Supports

Have you ever...

- Received mental health services? __Yes __No
- Received substance abuse services? __Yes __No
- Been hospitalized for psychiatric/mental health reasons? __Yes __No
- Had more than two primary caregivers throughout your life? __Yes __No

Challenging and Concerning Behavior

Do you ...

- Have difficulty controlling anger? __Yes __No
- Struggle with impulsivity or impulsive behavior? __Yes __No
- Lie frequently? __Yes __No
- Often avoid taking responsibility for misconduct? __Yes __No

- Lack remorse after doing something wrong? Yes No
- Spend time with others who are involved in criminal activity or who are considered a negative influence? Yes No
- Have a history of drug or alcohol use? Yes No

Have you ever...

- Carried a gun? Yes No
- Intentionally harmed or tortured animals? Yes No
- Been involved in setting fires? Yes No
- Shown any patterns of physical or verbal aggression at home? Yes No
- Been diagnosed with any mental health issues? Yes No
 - If you have significant mental health issues, do you feel like they're stable right now? Yes No
- Attempted suicide? Yes No
- Ever expressed any thoughts of suicide or harming others? Yes No
- Shown any signs or reports that they you may be experiencing paranoid thinking? Yes No
- Expressed any concerns or confusion about your sexual or gender identity? Yes No

Sexual Behavior

Have you ever...

- Engaged in undesired sexual or other physical contact with an unwilling person? Yes No
- Engaged in compulsive sexual behavior, such as excessive masturbation? Yes No
- Struggled with respecting the personal boundaries of others and/or engaged in inappropriate/over-familiar touching? Yes No

School/Academic History

Have you ever...

- Been held back or failed a grade? __Yes __No
- Been given an educational/IEP label of Specific Learning Disability or Emotional Impairment? __Yes __No
- Been suspended or expelled from school? __Yes __No
- Had a history of behavioral difficulties at school? __Yes __No
- Actively refrained from involvement in school activities or clubs? __Yes __No

Client Home Safety Checklist

Animals/Pets		
Do you have any pets?	__ Yes	__ No
<i>If yes:</i>		
• Do any of the pets live indoors?	__ Yes	__ No
• Do any of the pets live outdoors (do not come into the house)?	__ Yes	__ No
• Do any of your pets have a history of jumping or biting?	__ Yes	__ No
Is anyone in your family allergic to animals? (dander, saliva, fur, etc.)	__ Yes	__ No

Designated Therapy Area		
Do you have an area within the home designated for ABA therapy?	__ Yes	__ No
<i>If yes:</i>		
• Will the designated ABA therapy area be occupied or shared by other family members while therapy is in session?	__ Yes	__ No
• Is the path to the designated ABA therapy location free of clutter or potential hazards?	__ Yes	__ No
• Is there a walkout exit (door leading to outside)?	__ Yes	__ No
Do you have a bathroom that your ABA team can use during therapy?	__ Yes	__ No
Is your home smoke-free?	__ Yes	__ No
Does your home have air conditioning?	__ Yes	__ No
Are you able to keep the indoor/room temperature of your home between 65 and 80 F during ABA sessions?	__ Yes	__ No
Are there areas of the home that are "off-limits" for ABA therapy? <i>If yes, please indicate:</i>	__ Yes	__ No
Are there any indoor areas of the home that may be potentially dangerous (hole in wall/floor, broken staircase, home construction in progress, etc.)? <i>If yes, please indicate:</i>	__ Yes	__ No
Are there any other indoor safety concerns we should be aware of? <i>If yes, describe:</i>	__ Yes	__ No

Parking and Outdoor Security		
Do you have parking readily available for your ABA team?	__Yes	__No
<i>If yes:</i>		
• Can your ABA team park in the driveway?	__Yes	__No
• Is street parking readily available?	__Yes	__No
○ <i>If yes:</i> Is there an alternative place to park when street parking is unavailable (garbage day, snow emergencies, etc.)?	__Yes	__No
Does your home have a parking lot?	__Yes	__No
• <i>If yes:</i> Does the parking lot have reserved space or a specified area for guests?	__Yes	__No
Is your home (driveway and sidewalk) and street adequately cleared of snow and ice during winter months?	__Yes	__No
Does your neighborhood have adequate outdoor lighting when arriving and leaving session?	__Yes	__No
Does your home have access to a backyard, courtyard, park, or similar outdoor area?	__Yes	__No
• <i>If yes:</i> Will this outdoor area be available for use during ABA therapy?	__Yes	__No
Does your home have access to a large body of water (pool, hot tub, lake, pond, river, etc.)?	__Yes	__No
• <i>If yes:</i> Is there a fence and/or gate surrounding the large body of water to restrict access and maintain safety?	__Yes	__No
Are there outdoor areas near the house that could be potentially dangerous (hole in the ground, outdoor construction, barbed wire fence, etc.)?	__Yes	__No
<i>If yes, describe:</i>		
Are there any other outdoor safety concerns we should be aware of?	__Yes	__No
<i>If yes, describe:</i>		

Safety and Emergency Preparedness		
Are there firearms and/or guns in the home? • <i>If yes:</i> Are these items stored in a gun safe or locked up?	__ Yes __ Yes	__ No __ No
<i>Does your house have...</i>		
• Working smoke detectors? ○ <i>If yes:</i> Is there at least one working smoke detector on each level of your home?	__ Yes __ Yes	__ No __ No
• Working carbon monoxide detectors? ○ <i>If yes:</i> Is there at least one working carbon monoxide detector on each level of your home?	__ Yes __ Yes	__ No __ No
• A working fire extinguisher? ○ <i>If yes:</i> Where is it located?	__ Yes	__ No
Does your family have a designated outdoor gathering place in the event of a fire, natural gas leak, chemical exposure, or similar event? <i>If yes, describe:</i>	__ Yes	__ No

Resources and Materials		
<i>Do you have...</i>		
• A table and chairs available for use during therapy?	__ Yes	__ No
• An area within the home to securely store ABA materials?	__ Yes	__ No
• Highly preferred/ "favorite" items that could be offered during ABA therapy?	__ Yes	__ No
• Wi-Fi/Internet that can be used by your ABA team during therapy?	__ Yes	__ No

Client Needs and Preferences		
Would you like your ABA team to remove their shoes when indoors?	__ Yes	__ No
Are there any allergies or chronic medical conditions in the household that we should be aware of? <i>If yes, describe:</i>	__ Yes	__ No
Are there any specific foods that the ABA team should not bring into the home? <i>If yes, describe:</i>	__ Yes	__ No
Are there any other needs or preferences we should know about? <i>If yes, describe:</i>	__ Yes	__ No