Thank you for your interest in our program. To begin the intake process you will need to complete all the forms listed below that are applicable to your child.

- Patient Registration Form
- Consumer Financial Agreement Form
- HIPAA, Confidentiality, and Client's Rights Form
- Autism Scholarship Form
- Authorization of Release for current educational placement

Please also include current copies of the following documents:

- Individual Education Plan (IEP)
- Evaluation Team Report (ETR)
- Psychological Evaluation
- Prior Outside Assessments
- Front and Back of all insurance cards
- Proof of Residence (only applicable for the Autism Scholarship)

Please let us know if you have any questions or if we can help in any way.

Thank you,

The Intake Department

445 E. Dublin-Granville Rd., Worthington, OH, 43085
(614) 436-7837 Fax: (614) 436-8704
www.iamboundless.org

Patient Registration Form

Patient Information

Name:

Address:

Cell Phone:_______________________________
☐ Can leave a detailed voicemail

Home Phone:_______________________________
☐ Can leave a detailed voicemail

Email:

Please Circle your Primary Method of Communication:
Verbal Sign Language Written Augmentative Device

Personal Information

Please Check the Client's Current Living Situation:
☐ College Dorms ☐ Relative's Home ☐ Rent Home
☐ With Guardian (Not Parents) ☐ With Parents ☐ Own Home
☐ With Foster Parents ☐ 24-Hour Residential Care ☐ Other:________________________

Please Check the Client's Employment Status:
☐ Employed-Full Time ☐ Unemployed-Not Seeking Work ☐ Retired
☐ Employed-Part Time ☐ Student ☐ Disabled-Not in Workforce
☐ Unemployed-Seeking Work ☐ Ages 0-5 ☐ Other:________________

Please Check the Client's Race:
☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African American
☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Other Single Race
☐ Two or More Races ☐ Unknown

Is the Client of Hispanic Origin: ☐ Yes ☐ No ☐ Unknown
If "Yes", Please Check One of the Following:
☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other Hispanic

Is the Client a U.S. Citizen: Yes No

The Client's Religious Preference (if applicable):____

Is the Client Currently Serving in the Military: Yes No

Is the Client a Veteran: Yes No

Is this a Court Ordered Service: Yes No

Does the Client have Any Involvement with the Justice System: Yes No
If Circled "Yes", Please Check One of the Following:

- ☐ N/A
- ☐ Incarcerated-Jail
- ☐ Detained-Jail
- ☐ Arrested
- ☐ Incarcerated-Prison
- ☐ Mental Health Court
- ☐ Charged with a Crime
- ☐ Juvenile Detention Center
- ☐ Other:_________________

Highest Completed Education Level (please mark one of the following):

	Regular Education Classes		Continuing Education/College
	Special Education Classes (has an IEP)		Vocational Training
	High School Diploma/GED		

Current Education Status (please mark one of the following):

	Regular Education Classes		Vocational Training
	Special Education Classes (has an IEP)		Not Currently Enrolled
	Continuing Education/College		

Medical Information

Does the Client have Any Handicaps (please check all that apply):

- ☐ Deaf
- ☐ Blind/Severe Visual Impairment
- ☐ Developmentally Disabled
- ☐ Non-Ambulation
- ☐ Severe Medical Issues

Does the Client have an Advanced Life Directive: Yes No

SSI/SSDI Status:

	N/A		Potentially Eligible- Has not Applied
	Eligible- Receiving Payments		Determined to be Ineligible
	Eligible- Not Receiving Payments		Eligibility Status Unknown
	Eligibility Determination Pending		

Tobacco Use (please check one):

- ☐ Never Used
- ☐ Have Used/Not Current Use
- ☐ Occasional Use
- ☐ Regular Use
- ☐ Use Smokeless Tobacco
- ☐ Unknown/No Longer Allowed

Primary Care Physician: Yes No
If "yes", Please Provide the Information:
First Name:_________________________ Last Name:_________________________
Organization:_________________________ Phone:_________________________
Address:____

Current Behavioral Health Care Provider (if applicable):

First Name:______________________________ Last Name:__________________________________

Occupation:______________________________ Organization:_______________________________

Phone:____________________ Address:____

Previous Mental Health Services (please include ANY information- name of facility, dates, treatment)

____

____

____

___

Type of Services Received (check all that apply):

- ☐ State Hospital
- ☐ Psychiatric Hospital
- ☐ General Hospital
- ☐ Outpatient
- ☐ Residential(non-hospital)
- ☐ Substance Abuse/Outpatient

boundless™
inspiring the potential of people

Contacts

Name:______________________ **Relation:**______________
Cell Phone:___________________ **Home Phone:**_____________
Email:______________________ **Address:**______________________________
Circle ALL that Apply:

Financially Responsible | Emergency Contact | Guardian | Household Member | Schedule Appointments | Care Team Member

Name:______________________ **Relation:**______________
Cell Phone:___________________ **Home Phone:**_____________
Email:______________________ **Address:**______________________________
Circle ALL that Apply:

Financially Responsible | Emergency Contact | Guardian | Household Member | Schedule Appointments | Care Team Member

Name:______________________ **Relation:**______________
Cell Phone:___________________ **Home Phone:**_____________
Email:______________________ **Address:**______________________________
Circle ALL that Apply:

Financially Responsible | Emergency Contact | Guardian | Household Member | Schedule Appointments | Care Team Member

Name:______________________ **Relation:**______________
Cell Phone:___________________ **Home Phone:**_____________
Email:______________________ **Address:**______________________________
Circle ALL that Apply:

Financially Responsible | Emergency Contact | Guardian | Household Member | Schedule Appointments | Care Team Member

Name:______________________ **Relation:**______________
Cell Phone:___________________ **Home Phone:**_____________
Email:______________________ **Address:**______________________________
Circle ALL that Apply:

Financially Responsible | Emergency Contact | Guardian | Household Member | Schedule Appointments | Care Team Member

FINANCIAL AGREEMENT AND PAYMENT AUTHORIZATION

Consumer Name: ____

Boundless is committed to providing comprehensive services to each of our consumers. In order to do this we access a variety of funding sources.

The responsible party agrees to pay for any and all unpaid balances at the time services are rendered. The following are available funding sources to pay for services rendered. Not all funders may be used for services rendered. This list is of available options.

1. Commercial Insurance Carriers:
Boundless will bill most insurance carriers if proper paperwork is provided. Any outstanding balance, co-payment or deductible is due based on the insurance carrier's requirements. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from responsible parties. **Responsible parties are required to present a valid insurance card at the start of service and as needed throughout treatment.**

2. Medicaid: (Medicaid is always the last payer of resort)
Boundless is a Medicaid participating provider and will bill Medicaid accordingly for services rendered. Any outstanding balance, co-payment or deductible is due prior to an appointment. It is the responsibility of the responsible party to let Boundless know of all changes that affect the consumer's eligibility to receive Medicaid funded services which include, but are not limited to: loss of eligibility, family resources over limit, over-income requirement. **Responsible parties are required to present a valid Medicaid card at the start of service and as needed throughout treatment. Medicaid may include a monthly spend-down.**

3. Ohio Department of Education:
Boundless Center-based services utilize the Autism Scholarship Program scholarship in its entirety on an annual basis for all consumers. Boundless Outreach services utilize the ASP in its entirety or for a predetermined and agreed upon amount. Boundless will need a copy of the approval letter from the Ohio Department of Education (ODE) on an annual basis. It is the parent/guardian's responsibility to let Boundless know of all changes that may affect the consumer's scholarship fund, which include, but are not limited to: loss of scholarship, change of address, change of school district, or the addition of outside providers. If the above should occur and reduce available funds, it will be the parent/guardian's responsibility to pay the remaining balance for services rendered. It is required that parents/guardians sign each check monthly or authorize Boundless to endorse each check on your behalf.

4. Waiver: IO Waiver, Level 1,
Boundless program utilizes the IO waiver and Level 1 to pay for services rendered. Boundless may use any of the waivers in entirety on an annual basis or for a predetermined and agree upon amount. Extended Service is a limited center-based service. It is the consumer's or parent/guardian's responsibility to let BOUNDLESS know of all changes that may affect the consumer's waiver funding source, which include, but are not limited to: loss of waiver, change of address, addition of other waiver providers.

5. Rehabilitation Services Commission
The Rehabilitation Services Commission funding source can only be utilized for the Adult program and through the referral from the Rehabilitation Services Commission.

6. Private Pay: Method of Payment:
1. Cash
2. Major Credit Cards (Visa/MasterCard)
3. Personal checks made payable to Step By Step
4. Financing options for consumers who are credit worthy

FINANCIAL AGREEMENT AND PAYMENT AUTHORIZATION

7. Outstanding Balances:

Boundless is committed to continuing care of services, however if an outstanding balance exceeds $500.00, Boundless reserves the right to not schedule future appointments until the balance is below $500.00. Boundless will work with individual parties for payment plans and strategies to help reduce your balance to assist in your continuation of treatment.

For returned checks a $35 NSF charge is applied to balance owed. If not paid according to terms, the responsible party understands that Boundless reports to an outside collection agency. In the event that an account is turned over for collection, responsible party agrees to pay all additional fees assessed in the collection of the debt. These fees may include collection agency fees and attorney fees. The responsible party is ultimately responsible for all fees for service.

Please provide a copy of all insurance cards at each visit. If information is not available, payment is required in full. I authorize the release of any information concerning my health car, advised, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of insurance benefits otherwise payable to me, directly go to Boundless. I understand that my insurance may pay less than the actual bill for service or deem the service non-covered. I agree to be responsible for the payment of all services rendered on my behalf. I understand I am responsible for obtaining any referral authorization(s) that my insurance carrier requires. Failure to obtain necessary authorization(s) may result in non-payment of services by insurance carrier, making me responsible for all charges.

Payment Authorization

1. I authorize use of this form on all my insurance submission.
2. I authorize the release of information to my insurance company(s).
3. I authorize direct payment to my service provider.
4. I hereby permit a copy of my insurance card(s) to be used in place of the original.
5. I have supplied Boundless with a copy of my current insurance card(s).
6. I will update any changes in insurance information and address/phone number.
7. I understand any service that are provided from Boundless that are not covered by ANY insurance will be billed directly to the consumer.
8. I understand that the copay is due at the time of service.

I have read, understood and agree to the above financial policy for payment of professional fees.

____________________________________ ____________________

Consumer Signature Date

____________________________________ ____________________

Parent/Guardian Signature (if applicable) Date

____________________________________ ____________________

Parent/Guardian Signature (if applicable) Date

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(614) 436-7837 Fax: (614) 436-8704
www.iamboundless.org

HIPAA, CONFIDENTIALITY and CLIENTS RIGHTS

Consumer Name: ____

CONFIDENTIALITY
All information obtained about you or your child is strictly confidential. Information can be released only with a written, specific release signed by you or the parent/guardian (if applicable). Boundless staff members have access to confidential information and are required to demonstrate professionalism. Staff members must never, under any circumstances, mention the consumer's last name, address, or case history. Discussion of the consumer must be confined to individuals who are professionally involved with the consumer's assessment and diagnosis and/or enrollment. Any case discussions should be conducted in a professional manner and in an appropriate place, preferably behind closed doors. Consumers are never to be discussed in public.

LIMITS ON CONSUMER CONFIDENTIALITY

Boundless is responsible for the release of consumer PHI in the following circumstances:

- Any and all suspected child abuse incidents must be reported
- Any court orders to release records is received
- Duty to Warn- If you are a danger to yourself or others
- If you waive your right or give consent
- If the insurance company paying for services requests to review records

HIPAA
The signature below indicates that the consumer has received the HIPAA notice of Boundless Policies and Practices to Protect the Privacy of the consumer's health information or that the individual is the legal guardian of the consumer and has received the HIPAA notice of Boundless Policies and Practices to protect the privacy of consumers health information.
☐ I was offered a copy of the HIPAA rights policies and declined.___________

CLIENTS RIGHTS
I have been notified about the Client's Right's, Grievance Procedure and Abuse Policies as they apply to myself and/or my child. I understand that I may request a copy at any time through the compliance department.
For Office Use Only: I have attempted to obtain the consumer's signature on the form, however was unable to due to the following circumstances:

_______________________________________ ____________________

Consumer Signature Date

_______________________________________ ____________________

Printed Name of Parent/Guardian (if applicable) Date

_______________________________________ ____________________

Signature Parent/Guardian Signature (if applicable) Date

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Notice of Boundless Policies and Practices
to Protect the Privacy of Consumer's Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGY AND MEDICAL INFORMATION ABOUT CONSUMERS MAY BE USED AND DISCLOSED AND HOW THIS INFORAMTION CAN BE ACCESSED. PLEASE REVIEW IT CAREFULLY

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations.

Boundless may *use* or *disclose protected health information (PHI),* for *treatment, payment, and health care operations* purposes with *consent.* To help clarify these terms, here are some definitions:

A. "*PHI*" refers to information in the clinical record that could identify a consumer.
B. "*Treatment*, *Payment, and Health Care Operations"*
    1. *Treatment* is when we provide, coordinate or manage consumer's health care and other services related to their health care. An example of treatment would be when we consult with another heath care provider.
    2. *Payment* is when we obtain reimbursement for consumer's healthcare. Example of payment are when we disclose PHI to a health insurer to obtain reimbursement for consumer's health care or to determine eligibility or coverage.
    3. *Health Care Operations* are activities that relate to the performance and operation of our program. Examples of health care operations are quality assessment and improvements activities, business-related matters such as audits and administrative services, and case management and care coordination.

II. Uses and Disclosures Requiring Authorization

A. We may use or disclose Phi for purposes outside of treatment, payment, and health care operations when appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purpose outside of treatment, payment and health care operations, we will obtain an authorization from the legal guardian before releasing this information.
B. We will also need to obtain an authorization before releasing any psychotherapy notes. "*Psychotherapy notes"* are notes made about conversation during a private, group, join, or family counseling session between a consumer and a psychologist, which are kept separate from the rest of the clinical record. These notes are given a greater degree of protection the PHI.
C. A legal guardian may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. An authorization may not be revoked to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances.

A. *Child Abuse*: If, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Service Agency, or municipal or county peace officer.

B. *Adult and Domestic Abuse*: If we have reasonable cause to believe that an elder adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services.

C. *Judicial or Administrative Proceedings*: If a consumer is involved in a court proceeding and a request is made or information about evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from the consumer or the legal guardian or by a court order. The privilege does not apply when the consumer is being evaluated for a third party or where the evaluation is court order. The legal guardian of the consumer will be informed in advance if this is the case.

AUTHORIZATION TO RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Consumer Name:____ **Date of Birth:** __________________

I authorize that Boundless can Release/Exchange Info with Agency Name/or Professional Listed Below

☐ **I authorize Boundless to send my records to the agency/person listed below:**

☐ **I authorize Boundless to request my health information from the agency/person listed below:**

☐ I elect to **not** allow any of my Protected Health Information to be released at this time to the agency/name listed below and understand that to do so will require me to complete a new disclosure.

Name/Agency:____
Address: ____ City: ______________________ State: _______
Zip: ____________ Telephone: _____________________________ Fax: _________________________________

I authorize that Boundless can share the following information:
☐ My entire medical record ☐ My medical records dated from:___________________ to ___________________
☐ Protected Health Information relating to: ____
(Specify diagnosis, procedure, condition, injury, etc.)
☐ Other (please explain): ____

The above stated Disclosure or Release of my health information is being made for the purpose(s) of:
☐ Assessment and diagnosis, treatment, and coordination of services
☐ At the request of the Individual or Individual's personal representative
☐ Life insurance, automobile insurance or disability insurance claim
☐ Educational or Employment purpose (please specify): ____
☐ Other (please specify): ____

Authorization for Disclosure or Release of my health information will expire in 365 days from date of signature OR if before:
☐ Please specify date: ______________ ☐ Please specify event, if not a specific date: __________________________

I understand that if the person or entity to which Boundless is disclosing my information is not a doctor, health care provider or health plan, the information may not be protected by HIPAA, and that person may disclose that information to other non-covered entities. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health diagnoses and services, and treatment for alcohol and drug abuse.

I understand that my refusal to sign this authorization will not affect my ability to obtain treatment from Boundless. I understand I have the right to inspect or copy information disclosed or released by this authorization. I understand I may revoke (cancel) this authorization at any time. Revocation must be in writing. Boundless cannot be held responsible for having disclosed or released information in reliance on this authorization before receiving a written revocation. I understand that Boundless and its workforce are released from legal responsibility or liability for disclosing or releasing protected health information authorized by my signature below. I acknowledge I had an opportunity to ask questions before I signed and that I may receive a copy of the signed authorization.

_____________________________________ ___________________________________ ______________
Consumer/Client Print Name Signature Date

_____________________________________ ___________________________________ ______________
Parent/Guardian Print Name (if applicable) Signature Date

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www.iamboundless.org

Ohio | Department of Education

AUTISM SCHOLARSHIP PROGRAM
2018-2019 STUDENT APPLICATION

STUDENT INFORMATION ***Please use Birth Certificate for student data***

NAME: ______________ ______________ ______________
FIRST MIDDLE LAST

GENDER: MALE FEMALE

DATE OF BIRTH: ______________ CITY OF BIRTH: ______________

NATIVE LANGUAGE: ______________ LAST FOUR DIGITS OF SSN#: ______________

Current Grade Level 2017-2018: ______________

MOTHERS MAIDEN NAME: ______________ Grade Level 2018-2019: ______________

ETHNICITY:
Select Only One:

Asian/Pacific Islander | American Indian or Alaskan Native | Native Hawaiian or Other Pacific Islander
Black/Non-Hispanic | Multiracial | Hispanic | White/Caucasian/Non-Hispanic

IS YOUR STUDENT REGISTERED FOR HOME SCHOOLING? OR ATTENDING A PRIVATE SCHOOL?

REGISTERED AS HOME SCHOOLED: YES NO

IF NO, PROVIDE NAME OF PRIVATE SCHOOL STUDENT WILL ATTEND: ______________

PRIMARY GUARDIAN

I am the (check one)

Natural Parent
Adoptive Parent
Residential Parent
Legal Guardian
Guardian of student applying for scholarship funds
Student that is at least eighteen years of age

NAME: ______________ ______________ ______________
FIRST MIDDLE LAST

DATE OF BIRTH: ______________ SSN# LAST FOUR DIGITS: ______________

PHYSICAL ADDRESS: ______________

CITY, STATE,ZIP: ______________

PHONE: ______________ E-MAIL: ______________

RELATIONSHIP TO STUDENT: ______________

IN WHAT COUNTY DO YOU LIVE? ______________

IN WHAT SCHOOL DISTRICT DO YOU LIVE? ______________

SECONDARY GUARDIAN

NAME: ______________ ______________ ______________
FIRST MIDDLE LAST

DATE OF BIRTH: ______________ SSN# LAST FOUR DIGITS: ______________

PHYSICAL ADDRESS: ______________

CITY, STATE,ZIP: ______________

PHONE: ______________ E-MAIL: ______________

RELATIONSHIP TO STUDENT: ______________

Proof of Address

Proof of residency is required of all first-year and renewal applicants. Documents submitted must contain the parent/guardian's name, current address, and the date. The date should be current (within 60 days). Post office boxes are not acceptable. Most utility bills still show the "for service at" location, which will indicate where the gas, electric, etc. is being used.

Parents/guardians must document residency by providing the school with one of the following utility bills (to be accompanied with their request or renewal forms): Utility Bills: Electric, Gas, Water, Sewer/water, Cable/Internet, OR Lease/rental agreement and one (1) other official document, OR Monthly mortgage statement. Cell phone bills are not accepted. The entire utility bill must be submitted showing a matching service and mailing address. Additional information can be found on the scholarship webpage.

Authorization and Release of Information

I ____ AGREE TO THE FOLLOWING:
(**Parent Name**)

1. That the information provided on the application is true and correct;
2. I have submitted only one Autism Scholarship application for this student;
3. I have received the fee and service agreement;
4. I understand that acceptance of a scholarship relieves the school district of residence and the school district in which the student is entitled to attend school, if different, of the obligation to provide the child with FAPE;
5. I will inform the provider, my district of residence, and the department immediately of any change in the student's residential address, contact information or custody status;
6. I will inform the department, my provider and my district of residence of my withdrawal from the program and the return to the public school system;
7. I will inform the department of the addition or change of a selected service provider;
8. I will sign all scholarship checks received by my providers for my student in a timely manner. I understand that if I fail to endorse the scholarship checks to the provider, I will be responsible for paying the student's tuition and fees;
9. I understand that the scholarship can only be used for my child's education and the supportive service outlined in their IEP;
10. I understand that the scholarship can only be applied to the tuition and service fees of the enrolling Provider (s), and that I will be required to pay tuition and fees that exceed the amount of the scholarship and other fees and costs as prescribed by the policies of the provider.

I authorize the Ohio Department of Education, my school district of residence, the district of my nonpublic school and my selected providers to share the following information regarding my child: current and past Individualized Education Program (IEP), Evaluation Team Report (ETR), progress and interim reports.

BY SIGNING BELOW, I AGREE TO ALL THE ABOVE STATEMENTS.

I AUTHORIZE: ____ (Name of Provider) to submit an application on my behalf for the Scholarship Program through the Ohio Department of Education's electronic application system.

Signature of Primary Guardian:__________________________________ **Date:** ______________