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
- Informed Consent for Behavioral Health Services
- HIPAA, Confidentiality, and Client's Rights Form
- Autism Scholarship Form
- Authorization of Release for current educational placement
- Copy of Insurance Card

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

Registration Form

Individual Information

Name:

Address:

Cell Phone:_______________________	**Home Phone:** _______________________
☐Can leave a detailed voicemail	☐Can leave a detailed voicemail

Email:

Please check your primacy method of communication:

☐Verbal ☐ Sign Language ☐Written ☐Augmentative Device

Personal Information

Please check the individual'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 individual's employee status:

☐Employed-Full Time	☐Unemployed-Not seeking Work	☐Retired
☐Employed-Part Time	☐Student	☐Disabled-Not in Workforce
☐With Foster Parents	☐Age 0-5	☐Other:____________________

Please check the individual's race:

☐Alaskan Native	☐American Indian	☐Asian
☐White	☐Native Hawaiian or other Pacific Islander	☐African American
☐Two or More Races	☐Other Single Race	☐Unknown

Is the individual of Hispanic Origin: ☐Yes ☐No ☐Unknown
If "Yes", Please check one of the following:

☐Cuban ☐Mexican ☐Puerto Rican ☐Other Hispanic

Is the Individual a U.S. Citizen: ☐Yes ☐No

The individual's religious preference (if applicable):

Is the individual currently serving in the Military: ☐Yes ☐No

Is the individual a veteran: ☐Yes ☐No

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Is this a Court Ordered Service: ☐Yes ☐No

Does the individual have any involvement with the Justice System: ☐Yes ☐No
If checked "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 ☐Continuing Education/College

☐Special Education Classes (has an IEP) ☐Vocational Training

☐High School Diploma/GED

Medical Information

Does the individual have any handicaps (please check all that apply):

☐Deaf ☐Blind/Severe Visual Impairment ☐Developmentally Disabled

☐Non-Ambulation ☐Severe Medical Issues

Does the individual 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 ☐Has Used/Not Current Use ☐Occasional Use

☐Regular Use ☐Use Smokeless Tobacco ☐Unknown/No Longer Allowed

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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:_______________________________

Organization:______________________________ Phone:__________________________________

Address:____

Previous Mental Health Services (please include ANY information-Name of facility, Dates, treatment):

Facility Name Dates Treatment

____
____
____
____
____
____

Type of service Received (check all that apply):

☐State Hospital ☐Psychiatric Hospital ☐General Hospital

☐Outpatient ☐Residential (non-hospital) ☐Substance Abuse/Outpatient

Contacts

Name: ______________________ **Relation:** ______________________

Cell Phone: ______________________ **Home Phone:** ______________________

Email: ______________________ **Address:** ______________________

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

Name: ______________________ **Relation:** ______________________

Cell Phone: ______________________ **Home Phone:** ______________________

Email: ______________________ **Address:** ______________________

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

Name: ______________________ **Relation:** ______________________

Cell Phone: ______________________ **Home Phone:** ______________________

Email: ______________________ **Address:** ______________________

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

Name: ______________________ **Relation:** ______________________

Cell Phone: ______________________ **Home Phone:** ______________________

Email: ______________________ **Address:** ______________________

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

Financial Agreement and Payment Authorization

Consumer Name: ____

Boundless Behavioral Health, Inc. 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, Level 1, SELF

Boundless utilizes the SELF, IO and Level 1 waiver 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. 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. Private Pay: Method of Payment:

1. Cash
2. Major Credit Cards (Visa/MasterCard)
3. Personal checks (made payable to Boundless Behavioral Health)
4. Financing options for consumers who are credit worthy

6. 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

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Informed Consent for Assessment and Services

I understand that I am eligible to receive a range of services through Boundless Behavioral Health, Inc. The type and extent of services that I will receive will be determined following an initial assessment and through discussion with me. The goal of the assessment process is to determine the best course of treatment. I understand that treatment is a collaborative effort, with goals and objectives that are agreed upon by me and my provider.

Behavioral health treatment services available may include mental health assessment, therapy, assessment and diagnosis, psychiatry services, case management, and day treatment. I understand that services are provided based on medical necessity and I agree to participate in and receive the services, if applicable to my treatment plan. I understand that there are risks associated with treatment including: uncomfortable thoughts or feelings while working towards change; difficulty working through traumatic memories; or possible unwanted side effects of medications. I understand the benefits associated with treatment include: identifying patterns, problems, triggers, coping skills, symptoms and personal strengths; making progress, reaching goals, and decreasing symptoms; improving overall quality of life.

Speech language therapy services available may include assessment, diagnosis, treatment and consultative services. I understand that services are provided based on medical necessity and I agree to participate in and receive the services, if applicable to my treatment plan. I understand that there are risks associated with these services including: lack of progress towards goals; lack of improvement in communication skills or fine motor abilities. I understand the benefits associated with these services are: increasing communication skills in areas such as expressive language, receptive language, pragmatic language, articulation, phonology and AAC (augmentative and alternative communication).

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Occupational Therapy and Assessment services available may include assessment, diagnosis, treatment and consultative services. I understand that services are provided based on medical necessity and I agree to participate in and receive the services, if applicable to my treatment plan. I understand that there are risks associated with these services including: lack of progress towards goals; lack of improvement in communication skills or fine motor abilities. I understand the benefits associated with these services are: increasing communication skills in areas such as expressive language, receptive language, pragmatic language, articulation, phonology and AAC (augmentative and alternative communication).

Limits to Confidentiality: I understand that all information shared with the clinical staff at Boundless is confidential and that information will not be released without my consent. In most circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in specific circumstances. I further understand that there are specific and limited exceptions to this confidentiality in which Boundless staff are legally and ethically bound to report this information, which include but are not limited to the following:

- When there is a risk of imminent danger to self or another person.
- When there is suspicion that a client is being abused or neglected, is at risk for such abuse or neglect, or when abuse or neglect is reported to the staff.
- When a valid court order is issued for medical records.
- When informed of a felony crime that has been committed and not previously disclosed.

Supervision of Treatment: I understand that services may be provided by a range of health professionals, including some in training. Professionals-in-training are supervised by licensed staff. Some staff may be working under supervision of a licensed professional to perform the duties and functions of behavioral health services. The supervisor is legally responsible for helping assure that I receive effective and ethical quality care. I may ask to meet with my treatment provider's supervisor at any time.

I understand and consent to participate in the assessment and treatment provided by Boundless. I consent to the release of information for therapeutic, billing, supervision, and other purposes in connection with my treatment between and among Boundless clinicians, staff, and service contractors who perform work on behalf of Boundless. I have read and understand the above, and I have had opportunity to ask questions about this information. I understand that I may stop treatment at any time.

____ ________________

Print Consumer Name | Date of Birth

____ ________________

Consumer Signature | Date

____ ________________

Parent/Guardian Signature (if applicable) | Date

HIPAA, Confidentiality and Clients Rights

Consumer Name: ____

CONFIDENTIALITY

All information obtained by Boundless Behavioral Health, Inc. 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. Consumer Name:

□ 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

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, ______________________________ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Boundless
ADDRESS	ADDRESS 445 East Dublin Granville Road
CITY/STATE	CITY/STATE Worthington, Ohio 43085

☐ **Reciprocal Release Authorization** (when checked, authorizes two-way exchange of Protected Health Information between the above-named persons or entities).

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify)* ______________________

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* ______________________________

____

☐ Only the period of events from ______________________ to ______________________
☐ Other *(specify) (Billing, etc.)* ______________________
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes **ONLY** (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Boundless Intake Coordinator, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

____
(Specify new date)

I understand that Boundless will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

RV 2/11/2020

Instructions for Completing
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.

2. Section I, print your name or the name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. **CHECK THE RECIPROCAL RELEASE AUTHORIZATION BOX IF YOU WISH TO AUTHORIZE BOTH ENTITIES OR PERSONS LISTED IN SECTION II TO EXCHANGE YOUR PROTECTED HEALTH INFORMATION. THE ENTITY/PERSON OTHER THAN BOUNDLESS MAY ALSO REQUIRE YOU TO COMPLETE AN ADDITIONAL FORM OR FOLLOW PROCEDURES ESTABLISHED BY THAT ENTITY/PERSON TO AUTHORIZE THIS EXCHANGE OF INFORMATION. IF YOU CHECK THE RECIPROCAL RELEASE AUTHORIZATION BOX AND LATER DECIDE TO REVOKE THIS AUTHORIZATION, YOU MUST NOTIFY BOTH ENTITIES OR PERSONS OF THAT REVOCATION IN WRITING.**

5. Section IV, check the appropriate box as applicable.

   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2019, to Feb. 1, 2020.

   c. **Other *(specify)*** -- e.g., Billing.

   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**

   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

6. Section V, if a different *expiration* date is desired, specify a new date.

7. Section V, please sign (or mark) and date.

8. A copy of the completed authorization form will be given to you.

Ohio | Department of Education

AUTISM SCHOLARSHIP PROGRAM
2020-2021 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 2019-2020: ____________

MOTHERS MAIDEN NAME: ____________ Grade Level 2020-2021 ____________

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), data for the IEP and ETR development including 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:** ____________