



Montessori Autism Programs and Services, Inc.

300 Natoma Street, Folsom, CA 95630 916-357-5837

Greetings,

Thank you for choosing MAPS as your provider!

Thank you so much for your interest in our programs. We take great pride in providing the most effective, comprehensive and enjoyable of programs for your child. We offer a wide range of programs that are tailored to meet the needs and styles of each family. We foster a wonderful community of children, families and friends and we would love for your family to become part of it. In order to begin intake for your child and provide an assessment we need to learn more about your child.

The MAPS assessment procedure is performed upon each child that enters into our program in order to evaluate the baseline skill levels of your child in developmental patterns associated with social skill development, play preferences, strengths, style and impulse control abilities. This information will allow us to properly place your child with children who share their interests.

The assessment has very specific steps and this document is designed to help you understand what the steps are and what your responsibilities entail. The steps are:

Step One:

The ***Novice Player Parent Packet*** is to be completed by you before your child begins the assessment. It contains:

- An Emergency Card
- A Parent Health Report
- A Physician's Report
- The Rights of an Individual Poster
- Right of an Individual Signature page
- The MAPS Parent Roles and Responsibilities
- HIPAA "Notice of Privacy Practices" Statement
- Client Financial Responsibility
- Client Availability Form
- Novice Players Brochure

In addition, we require a copy of the following:

- Client's Immunization Record
- Client's Health Insurance card (front and back)
- Diagnosis Report from the diagnosing physician



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Step Two: *Initial Parent Meeting*

The Assessor will meet with you and ask a series of questions that help us learn about your child.

We believe that parents are the experts and want to know all of those wonderful ways that your child communicates and interacts with the people in his or her world.

- The last responsibility of step one is for you, as the parent, to help facilitate Step Two, which is a ***Natural Play Environment Observation***. This observation takes place at one of the child's natural play environments. A Natural Play Environment is any place that the child typically plays. We often choose to observe the child at school, during recess, but places like gymnastics, karate, or even the child's neighborhood park are also appropriate. We ask that you contact your child's teacher and give to them our *Teacher's Perspective Packet*, if you have not already done so and help us arrange a time that we can perform our observation.

Step Three: *Natural Play Environment Observation*

We observe your child in one of his/her Natural Play Environments. The Parent has no responsibilities during this observation other than helping facilitate its occurrence.

Step Four: *MAPS Observation*

We observe your child in one of our play groups on the MAPS Central campus. We ask that you bring your child at the prearranged time and allow us to observe him/her for 1-1.5 hours. It is not preferred that you remain in the room with your child – because natural play is often difficult to observe when a parent is in the room. Please feel free to spend some time at the beginning, making sure that your child is well accommodated and then you are free to remain on campus or close by.

Please note that the assessment process is time sensitive.

As soon as these steps are completed we will submit a complete assessment report to you and your funding agency (ALTA and/or Insurance Company). We will meet with the family and discuss our findings.

Children can begin individual and group programs when they have acquired instructional control and a form of basic communication. If your child is not yet ready to participate in a group program at MAPS we can, for insurance funded clients provide a program to prepare your child for the inclusion programs. Some children just need a little more time to mature and gain some skills before they are ready to participate.

Once services are approved by the funding agency an **Orientation Meeting** will be scheduled with you to explain the procedures and policies of the MAPS Program. You will be given a Parent handbook, a MAPS calendar and will get a chance to meet your child's Play Guide. This is a great time to schedule your Update Meetings and ask any questions.

Thank you for your time and interest in our Program and please know that we are always available should you have any questions.

All our best,
MAPS



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Client Availability Form

Client's Name: _____ **DOB:** _____ **Age:** _____

We do our best to accommodate your request for days and times. However, program placement is subject to play group openings at the time of assessment/admission.

Early childhood (3-7 years old) playgroup times:

1:00-2:30, 1:15-2:45, 2:30-4:00, 2:45-4:15, 4:00-5:30, 4:15-5:45

School age (7-9 years old) playgroup times:

3:00-4:30, 4:30-6:00

Please indicate days/times your child would be available for play group services (mark one or more):

First Choice:

Monday/ Wednesday/Friday	
Tuesday/Thursday	

Second Choice:

Monday/ Wednesday/Friday	
Tuesday/Thursday	

Thank you for taking the time to fill out our interest form. We will let you know the schedules as soon as possible

Signature of Parent of Legal Guardian

Date

Print Name

Relationship to Client



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Release of Information

As the parent/guardian of :

Name of Client

I authorize:

Name of Entity of Individual

to share information regarding my child with Montessori Autism Programs and Services, Inc. I am aware this information will only be shared if deemed necessary and appropriate to my child's progress with his/her program with Montessori Autism Programs and Services, Inc.

Signature of Parent of Legal Guardian

Date

Print Name

Relationship to Client



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Client Financial Responsibility

Client Name: _____

Today's Date: _____

Montessori Autism Programs & Services, Inc. (MAPS) requires this form to be completed by all clients. We appreciate your cooperation. If you have any questions please feel free to contact us at (916) 357-5837.

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1. **Financial Responsibility:** I understand that MAPS will make all reasonable attempts to bill my insurance company first, and will work with me to address potential problems. However, in the event that my insurance company does not pay for any portion of services provided, I agree and acknowledge that I am responsible for any fees remaining.

Signature of Client or Legal Guardian: _____

2. **Authorization to Release Information:** I authorize MAPS, to release information requested by my insurance company to complete my claim.

Signature of Client or Legal Guardian: _____

3. **Authorization to Pay Claims to MAPS:** I authorize payment from the insurance company to be directly sent to MAPS. This allows MAPS to file claim on my behalf.

Signature of Insured: _____

Print Name: ----- _____



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Nadja Martins, BCBA

Eligibility Verification Request

Parents/Guardians:		
Email:		
Address:		
Phone #s:		
Child's Name:	DOB:	Age:
Primary Insurance Company:	Primary Insurance Phone:	Member ID:
Group#:	Subscriber Name:	Subscriber DOB:
Subscriber Social Security#:		Self-funded: (yes/no)
Secondary Insurance:	Secondary Insurance Phone:	Member ID:
Group#:	Subscriber Name:	Subscriber DOB:
Subscriber Social Security#:		Self-funded: (yes/no)
Diagnosis:	Secondary Diagnoses:	
Prescribing Doctor:	Prescribing Doctor Phone:	

Thank you!



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General Information Form

Client's Name:		D.O.B:	
Nickname:		Age:	
Legal Guardian 1:			
Relationship:			
Cell Phone #:		Work Phone #:	
Mailing Address:			
Email Address:			
Legal Guardian 2:			
Relationship:			
Cell Phone #:		Work Phone #:	
Mailing Address:			
Email Address:			
Client's Primary Residence:			
Home Phone Number: () -		Alternative Number: () -	
Number of Siblings in home:		Ages:	
Emergency Contact:		Phone number(s):	
Relationship to Client:			

Education Information

School:			Address:		
Current Teacher:			Contact:		
Schedule:	Monday	Tuesday	Wednesday	Thursday	Friday



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	From:	From:	From:	From:	From:
	To:	To:	To:	To:	To:

Medical Considerations

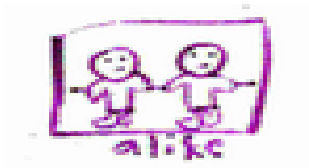
Primary Diagnosis:	Secondary Diagnoses:
Doctor's Name:	Contact:
Medical Concerns:	
Medications:	
Dietary Restrictions:	
Allergies:	
Comments:	

Clients Range of Services

	Schedule	Location	Provider
Speech and Language Pathology			
Occupational Therapy			
Functional/Adaptive Behavior Therapy			
Other:			
Name of Person Completing this Form:		Relationship to Client:	

Today's Date: _____

Signature: _____



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Authorization for Dismissal

This form is to be filled out with the names of those people who have your permission to pick up your child from MAPS. Remember to inform these people that they must present proper identification before we will release your child into their care. We would appreciate advanced notice, if at all possible, that someone else will be picking up your child.

Child's Name: _____

Persons Authorized to pick up your child.

Name	Relationship	Contact Phone #

Signature of Parent of Legal Guardian

Date

Print Name



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HIPAA “Notice of Privacy Practices” Statement

This notice describes how medical information about you (“Protected Health Information”-PHI) that is in Montessori Autism Programs & Services, Inc. (M.A.P.S.) possession, according to the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client/patient rights regarding use and disclosure of your PHI. Please read it carefully.

Who Will Follow This Notice

This notice describes the medical/healthcare information privacy practices of M.A.P.S. and that of any third party that assists in the administration of insurance carrier claims.

Our Pledge Regarding Medical/Healthcare Information

We understand that the information about you and your health is personal. M.A.P.S. understands that keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. This notice applies to all the health care information we maintain. M.A.P.S. is required by law to:

- Ensure that health care information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical/healthcare information about you; and
- Follow the terms of the notice.

How We Collect Information About You

M.A.P.S. and its employees collect data through a variety of means including but not limited to letters, phone calls, emails, voice mails, and from the submissions of authorization that is either required by law, or necessary to process services or other requests for assistance through our organization.

How We May Use and Disclose Health Information About You

The following categories describe different ways that we use and disclose medical information. Information is only used as is reasonably necessary to process your approval to receive services or to provide you with services which may require communication between M.A.P.S. and health care providers, service providers, insurance companies, and other providers necessary to: verify your medical information is accurate and to determine the type of services you need.

Treatment, Payment, and Organizational Operations:

We may use or disclose your PHI to obtain payment for services we provide to you or to determine eligibility or coverage for services. We review your healthcare information and submit claims to payers you have agreements with to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your PHI in connection with clinical quality measures and in order to operate our office in an efficient and quality manner. This may include quality assessment and evaluation, licensure/credentialing activities, providing appointment reminders, training, audits, administrative/office services, case management/case coordination, among similar activities.



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Professional Records

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in three (3) sets of professional records. One set constitutes the Clinical Records, the second set is the Personal Notes, and the third are the Billing Records.

(1) The Clinical Record includes information about reasons for seeking our professional services; the impact of any current or ongoing problems or concerns; assessment; consultative; or therapeutic goals; progress towards those goals; a medical, developmental, educational and social history; treatment history; any treatment records that we receive from the providers; releases; reports of an professional consultations; formal clinic notes of treatment and treatment data; and any clinical or evaluation reports that have been sent to anyone, including your insurance carrier. The client or his/her authorized legal representative may examine and/or receive a copy of the Clinical Record, if requested in writing. In most situations, we are allowed to charge a fee for copying (and for certain other expenses) plus postage.

(2) Personal Notes are taken by our professionals for clients that we provide direct ABA treatment to. While the content of the Personal Notes vary from client to client, most are anecdotal notes related to progress and future goals, reference to conversations, and hypotheses of the professional in order to assist him/her to provide you with the best treatment. These notes are kept separate from the Clinical Record as they are for the use of the professional alone, and are not available to the client or his/her authorized representative, or anyone else, including third party payers. Your signature below waives all rights, now and in the future, to accessing these records in any form under any circumstance. Insurance companies or other funding sources cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

(3) Billing Records are kept separate from the Clinical Record and Personal Notes. The Billing Record for each client can vary based on individual circumstances, but can include authorization for services, invoices, and verification of services, releases, billing statements, credit card authorizations, financial agreements/contracts, and related confidential financial records. The client or his/her authorized legal representative may examine and/or receive a copy of the Billing Record, if requested in writing. In most situations, we are allowed to charge a fee for copying (and for certain other expenses) plus postage.

Uses Pursuant to an Authorization:

As permitted by federal and state law, we may disclose our PHI with your consent. You may generally revoke your consent in writing at any time to the extent we have not already relied on that consent. In other words, we cannot take back any uses or disclosures already made with your permission. It is understood that such consent may authorize the release of information to which you have not had access or to information that has not been generated at the time of the execution of the release.



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Further Disclosures:

We follow federal and state laws that tell us when we **are required** to share health care information, even if you do not sign an authorization form. Federal and state laws do not require patient/client consent for the following disclosures:

- **Abuse or Neglect:** We must report information that leads us to reasonably suspect child abuse or neglect, or that an elderly or disabled adult is in need of protective services. We must also comply with a request from state and federal agencies to release records relating to abuse or neglect investigations.
- **Judicial/Administrative Proceedings:** We must comply with an appropriately issued court order or subpoena that requires that we release your PHI.
- **Serious Threat to Health or Safety:** We may be required to disclose your PHI to protect you or others from a serious threat of harm, including, but not limited to: contagious diseases; firearm injuries and other trauma; and reactions to problems with medications or defective medical equipment; to the police when required by law.
- **Others We May Be Required to Share Your Information With:** We may be required to disclose your personal health information: to the government to review how our programs are working; to an insurance company who needs to know if you received services from us; to Worker's Compensation for work related injuries; to the government during the course of an investigation or for serious threats to public health or safety.

Patient/Client Rights

- You have a right to request restrictions on certain uses and disclosures of PHI; however, federal law does not require that we comply with all requests. You can request and receive confidential communications of PHI by specified means/alternative locations.
- You may inspect or obtain a copy of PHI in certain circumstances when requested in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. M.A.P.S. may deny your request to inspect and copy in certain, very limited, circumstances; if denied access, you may request that the denial be reviewed.
- If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information in writing, so long as we maintain that information in our records. Federal law does not require us to agree to each such request (for example, when the information was not created by us). We will answer your questions about the amendment process.
- You have a right to receive an accounting of most disclosures of PHI, where such disclosure was made for any purpose other than treatment, payment, or M.A.P.S. operations, for which you have not provided consent. Requests must be made in writing, state a time period not longer than six years, and may not include dates before _____. Your request should indicate what form you want (paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we will charge you for the costs of providing the list. We will notify you of the cost involved and ask for your consent.
- You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a



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limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member. We are not required to agree to your request. To request restrictions, you must make your request in writing. In your request, you must tell us: what information you want to limit; whether you want to limit our use, disclosure, or both; and to whom you want the limits to apply.

- You have the right to request that we communicate with you about medical matters in a certain way or a certain location. To request confidential communications, you must make your request in writing. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- You have a right to obtain a paper copy of this notice for us upon request.

Changes to This Notice

M.A.P.S. reserves the right to change this notice. We reserve the right to make revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will send you a copy of any changed notice in the U.S. mail within 30 days. Revised notices will contain the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

As Client or Parent/Legal Guardian of Client, I am verifying that I have received two (2) copies of Montessori Autism Programs & Services, Inc. HIPAA “Notice of Privacy Practices”, one (1) copy to keep for my own records. By signing below, I am verifying that I have read the Notice of Privacy Practices.

Client Full Name:	Date of Birth:
Print Name of Client’s Authorized Representative:	Relationship to Client:

Signature of Client’s Authorized Representative: _____

Date: _____



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Notice: This document contains information from Montessori Autism Programs & Services, Inc., which is confidential or privileged. The information is intended to be sent to the individual or entity named above. If you are not the intended recipient, be aware that any disclosure, copying, or distribution or use of the contents of this information is prohibited. If you have received this document in error, please notify us by telephone at (916) 357-5837

CONFIDENTIAL