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. It is suggested that you print the forms listed below and please have these prepared for your tour.

- Registration Form
- Financial Agreement and Payment Authorization Form
- Inform Consent for Behavioral Health Form
- HIPAA, Confidentiality, and Client's Fights Form
- Autism Scholarship Form (if applicable)
- Authorization of Release for current educational placement (Please list your school district)

Please also provide 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 (This a requirement of the Autism Scholarship Program. Accepted is a utility bill, lease agreement, etc.)

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

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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

445 E. Dublin Granville Rd., Worthington, OH, 43085
1-800-409-2729 Fax: 614-436-8704
www.iamboundless.org

Informed Consent for Behavioral Health Services

I hereby 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. 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.

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 behavioral 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.

Insurance/Fees: I authorize Boundless to bill my insurance and release pertinent information to my insurance carrier. I understand that I am responsible to pay all co-pays, deductibles, and any fees unpaid by insurance for any reason. I understand I am responsible for understanding by benefit plan and informing Boundless of any changes in my insurance coverage. I understand that payment of all fees is due at the time of service.

I understand and consent to participate in the assessment and treatment at 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 contracts who perform work on behalf of Boundless. I have read and understand the above, and I have had opportunity to ask questions about them. 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

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: ______________

THIS FORM MUST BE RETURNED TO THE PROVIDER WITH CURRENT PROOF OF ADDRESS

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:** ____________

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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

445 E. Dublin-Granville Rd., Worthington, OH, 43085
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www.iamboundless.org