INFINITE ABILITIES LLC
GOING BEYOND THE SPECTRUM

Name of Client:_____

New Client Paperwork/Consents for Treatment

- ☐ **Required Client Paperwork**
- ☐ **Behavior Analyst Expectations**
- ☐ **Behavior Assistant Expectations**
- ☐ **Abuse & Neglect Policy**
- ☐ **Authorization to Release Information**
- ☐ **Client Bill of Rights**
- ☐ **Client Information Form**
- ☐ **First Aid Release Form**
- ☐ **Steps for Submitting Grievance**
- ☐ **Title VI Signature Page**
- ☐ **Informed Consent for Treatment**

INFINITE ABILITIES LLC
GOING BEYOND THE SPECTRUM

Name of Client:_____

Informed Consent for Treatment

The undersigned acknowledges that Infinite Abilities, hereinafter referred to as Infinite Abilities, is providing services to, or for the benefit of the below named client and is requiring, as partial consideration for providing said services, the execution of this Informed Consent for Treatment which is being executed by the undersigned as the natural parent, guardian, or other responsible party for the below named patient/client. The specific terms of this Informed Consent for Treatment are as follows:

• Infinite Abilities providing services including, but not necessarily limited to behavior analysis services, behavior assistant services, evaluation, program development, and treatment of the below named client. • Infinite Abilities will provide the aforementioned services in a professional manner and will take every precaution within reason to insure the safety of the client. • The undersigned herby acknowledges the potential risk of inadvertent injury to the client. Infinite Abilities has informed the undersigned that treatment strategies are often play-based or interactive in nature and accordingly, can potentially pose risk of unintended injury to the client. • The undersigned hereby acknowledges the potential risks of injury based on the strategies implemented by Infinite Abilities and consents to the same despite the disclosed risks. Furthermore, the undersigned herby waives, on behalf of the undersigned as well as the patient, together with the heirs, devisees, or assignees of the undersigned or the patient, any and all liability for personal injury, physical, or otherwise, which may be incurred by the client as a result of the provision of services. • The undersigned acknowledges and agrees that the execution of this form, and the promises and conditions as set forth herein, is partial consideration for the provision of services to the client by Infinite Abilities. • The undersigned acknowledges and agrees that if the status of legal guardian should change, they will immediately notify Infinite Abilities, of the name, address, and telephone number of the person who has assumed guardianship of the below-named client • The undersigned acknowledges and agrees that they have legal authority to consent to treatment, release of information, and all legal issues involving the below-named client. Upon request, I will provide Infinite Abilities with proper legal documentation to support this claim.

By signing below I verify that I have read and understand the above Informed Consent for Treatment, agree to adhere to it, and wish to have Infinite Abilities provide services and that the provision of services will be contingent upon adherence to this agreement and full participation by the caregiver/guardian. If at any time there is not full participation and cooperation by the caregiver/guardian, I understand Infinite Abilities may terminate services following notice of 30 days. I also understand that I may discontinue services at any time and will be held accountable to pay for services rendered up to that point.

_____**Signature of Client** _____**Date**

_____**Signature of Caregiver/Guardian** _____**Date**

_____**Signature of Provider** _____**Date**

Client Name: _____

DOB: _____

INFINITE ABILITIES LLC
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This authorizes Infinite Abilities, 1119 E Rushwood DR, Derby, KS 67037 and its subsidiaries, affiliates, and clinicians, the ability to release or obtain protected health information concerning the above named client. Protected health information may relate to my past, present or future physical or mental health condition, and the provision of my health care, or payment for my health care services. This information may be disclosed to obtained from the following agencies (e.g., doctor's office, school), and their employees (indicate agency name/address):

_____

_____

Delivery Method: Mail Phone Fax Email

I authorize ALL Health information to be disclosed OR only the following information is/are authorized for disclosure (check all to be released)

Client Information Sheet:
- ☐Individualized Treatment Plan
- ☐Treatment Plan Reviews
- ☐Psychosocial Evaluation
- ☐Behavioral Program
- ☐Discharge Summary
- ☐Progress Summary

- ☐Individual Education Plan (IEP)
- ☐Psych Educ. Assessment
- ☐Report Cards/Transcripts
- ☐Behavioral Report
- ☐Special Report
- ☐Psychological Evaluation
- ☐Medication Management Visits

- ☐Speech/Language Evaluation
- ☐Hearing Screening
- ☐Medical / Physical History
- ☐Immunization Record
- ☐Neurology Report
- ☐Psychiatric Evaluation
- ☐Progress Notes

Expiration: This authorization expires or (exp. Date) Purpose of the Release: At the request of the Individual Assessment Treatment Coordination Disability Determination Other – Please specify To obtain information for Brief Behavioral Health Status Exam

Other Information: • I understand that Infinite Abilities, cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. • I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Infinite Abilities • I understand that I may revoke this Authorization in writing at any time, however, I cannot revoke authorization for action that has already been taken. I further understand that I must provide any notice of revocation in writing to the Business Office at the address listed above.

A copy of this release shall be valid as the original. THIS CONSENT EXPIRES I YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

Legal Guardian Name & Signature:_____ **Date: _____**

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Behavior Analysis Services Expectations

Name of Client:_____

Behavioral Analyst Description: A Behavioral Analyst provides community-based therapy support services. The Behavioral Analyst provides an assessment for the consumer along with the development of a plan of care and insures the implementation of the plan.

Behavior Analyst Responsibilities:

• If requested and approved a Functional Behavioral Assessment (FBA) will be completed within 30 days of receipt of the Personal Service Authorization (PSA). • Development of a Behavior Analysis Service Plan (BASP) that is incorporated into the Individual Service Plan (ISP) will be due within 90 days from receipt of the PSA. • Provides services only within the margins of the PSA. • Submit applicable plans to the Local Review Committee, completes revisions and submits updates as necessary and required. • Implements the BASP as well as train and monitor caregivers. • Collects and analyzes data received from caregivers. • Complete Case Note / Client Contact Log with signed confirmation of services. • Complete Quarterly Service Summaries and Annual Reports in relation to the Support Plan effective date, to include Monthly Graphs. • Submit all Summaries and Reports to Local APD office each month by all required deadline. • Active member of the consumer's treatment team. • Attendance at the consumer's ISP meeting when requested. • Regular correspondence with the consumer's Support Coordinator and relevant caregivers • Coordinate appointments for service delivery. • Provide on-sight services in the home, community, work place or ADT

By signing below I am indicating that I fully understand the role my Behavior Analyst has in providing me with exceptional services. I have also had the responsibilities of the Behavior Analyst explained to me.

Signature of Client:_____ **Date:**_____

Signature of Behavior Analyst or Certified BCBA:_____ **Date:**_____

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Infinite Abilities

Name of Client:_____

Behavior Analysis Services Expectations: _____

Behavioral Assistant or Registered Behavior Technician Description:

A Registered Behavior Technician provides community-based therapy support services. The Registered Behavior Technician works with a Behavior Analyst to implement the behavior plan, collect data, and train caregivers.

Behavior Assistant/ Registered Behavior Technician Responsibilities:

• Provides services only within the margins of the Personal Service Authorization (PSA). • Implements the Behavior Analysis Service Plan (BASP) as well as train and monitor caregivers. • Complete Case Note / Client Contact Log with signed confirmation of services • Complete Quarterly Service Summaries and Annual Reports in relation to the Support Plan effective date, to include Monthly Graphs. • Submit all Summaries and Reports to Local APD office each month by all required deadline. • Active member of the consumer's treatment team. • Attendance at the consumer's ISP meeting when requested. • Regular correspondence with the consumer's Support Coordinator and relevant caregivers • Coordinate appointments for service delivery. • Provide on-sight services in the home, community, work place or ADT

By signing below I am indicating that I fully understand the role my Behavior Assistant has in providing me with exceptional services. I have also had the responsibilities of the Behavior Assistant explained to me.

Signature of Client:_____ **Date**:_____

Signature of Registered Behavior Technician:_____ **Date**:_____

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Name of Client:_____

Client Bill of Rights:

I have the right to dignity, privacy, and humane care, including the right to be free from sexual abuse in my residence. I have the right to practice my faith. I have the right to receive services which protect my personal liberty and those services will be provided in the least restrictive conditions necessary to achieve the purpose of treatment. I have the right to participate in a program to promote my educational and/or training goals without prejudice of age or disability. I have to the right to sex education, marriage, and family planning when applicable. I have the right to social interaction and participation in community activities. I have the right to physical exercise and recreational activities. I have the right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse or neglect. I have the right to consent to or refuse treatment, subject to the provisions of s. 393.12(2)(a) or chapter 744. I have the right to receive benefits or participate in activities which receive public funds. I have the right to vote. I have the right to unrestricted communication; mail, telephones, visitation, personal possessions (clothing, personal effects), monies (in accordance to s.407.12. Included in my right to have personal possessions will be the access to individual storage space for my private use. I have the right to appropriate medical and dental care. I have the right to humane discipline. NO treatment plan or behavior plan will be used which contain the use of noxious of painful stimuli. My records will remain confidential.

A copy of this Bill of Rights was explained and provided to me.

Signature of Client:_____ **Date**:_____

Signature of Caregiver/Guardian:_____ **Date**:_____

Signature of Infinite Abilities Provider:_____ **Date**:_____

INFINITE ABILITIES LLC
GOING BEYOND THE SPECTRUM

Name of Client:_____

Abuse/Neglect Policy

All Infinite Abilities Personnel are legally and ethically bound to report situation of suspected abuse and/or neglect. Our policy is to report suspected abuse/neglect immediately to the appropriate authorities. The administrator will immediately report such knowledge or suspicion to the central abuse registry and tracking system of the Department of statewide toll-free telephone number.

1-800-ABUSE or TTY users call 1-800-453-5145 condense I understand this policy and by signing acknowledge my agreement with the stipulations in this policy.

Signature of Client:_____ **Date**:_____

Signature of Caregiver/Guardian:_____ **Date:**_____

Signature of Infinite Abilities Behavior Analysis Provider:_____ **Date**: _____

INFINITE ABILITIES LLC
GOING BEYOND THE SPECTRUM

Name of Client:_____

First Aid Release Form

I agree to allow personnel of Infinite Abilities to administer simple first aide in the form of cleaning and bandaging a cut, burn, or scrape. I understand that Infinite Abilities personnel are not authorized to administer medications and medical attention beyond simple bandaging. Any injury that occurs will be referred out to the nearest hospital and/or critical care facility or by dialing 911. Infinite Abilities personnel are not authorized to transport injured recipients.

I agree to the terms as stipulated.

Signature of Client:_____ **Date:**_____

Signature of Caregiver/Guardian:_____ **Date:**_____

Signature of Infinite Abilities Behavior Analysis Provider:_____ **Date**:_____

INFINITE ABILITIES LLC
GOING BEYOND THE SPECTRUM

Name of Client:_____

Date:_____

Dear Infinite Abilities, Client and Caregiver/Guardian, As a client of Infinite Abilities, you are protected against discrimination by Title VI of the Civil Rights Act of 1964.

Title VI requires that no person in the United States of America shall, on the grounds of race, color, sex, or national origin, be excluded from the participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which a providing company receives federal financial assistance.

Infinite Abilities, assures full compliance with Title VI of the Civil Rights Act of 1964, the Civil Rights Restoration Act of 1987, and related statues and regulations in all programs and activities provided.

Any client who believes they have been distressed by an unlawful discriminatory practice under Title VI has a right to file a formal complaint. Any such complaint must be in writing and filed with Infinite Abilities, within one hundred eighty (180) days following the date of alleged discriminatory occurrence.

Title VI Complaint Forms can be obtained and/or to register a Title VI complaint please contact our Human Resources and Administration Team at the email address listed below.

Ashleymichaels@infiniteabilities.co

Sincerely,

Company President

Title VI Receipt Signature

INFINITE ABILITIES LLC

GOING BEYOND THE SPECTRUM

By signing below I verify that I have received the Title VI letter from Infinite Abilities

Name of Client:_____

Signature of Client: _____ **Date**:_____

Signature of Caregiver/Guardian:_____ **Date:**_____

Signature of Infinite Abilities Provider:_____ **Date:**_____

INFINITE ABILITIES LLC
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Steps for Submitting Grievance

Recipient name: _____

Date: _____

Explanation of steps for filing a grievance: 1. Notify Infinite Abilities President, of the nature and issue at hand. a. May be reached via phone at 229-251-7930 b. May be reached via email: ashleymichaels@iabilitiesaba.com 2. Provide any documentation you have of the issues at hand. 3. Infinite Abilities will do everything to satisfy our clients in any way possible, and promise to address your concern in a timely and effective manner.

Signature of Client:_____ **Date**:_____

Signature of Caregiver/Guardian:_____ **Date**:_____

Signature of Infinite Abilities Provider:_____ **Date**:_____

INFINITE ABILITIES LLC

GOING BEYOND THE SPECTRUM

Grievance Report

Recipient name: _____

Date of report: _____

Name of person requesting review: _____

Relationship to recipient: _____

Nature of complaint:

_____
_____
_____
_____

Resolution:

_____
_____
_____

Date of Resolution: _____

Date sent to: Requestor: _____

WSC: _____

Others: _____