CONFIDENTIAL INFORMATION

Intake Packet

Thank you for selecting Spectrum of Hope to help meet the needs of your child. I am so excited to work with you!

The attached packet of information will inform you about policies and procedures and allow time to gather information prior to your intake appointment.

Thank you for trusting us to work with you and your family. I understand that forms can sometimes seem difficult or time-consuming, but this information will assist in providing the very best treatment to your child. If you need any assistance, please don't hesitate to contact us.

We look forward to meeting you and your child!

Casey Ayer, MS, BCBA-Clinical Director
Phone: (912)432-6748
Email: caseyayer@spectrumga.com
Fax: 866-467-4321

Samantha Moorhouse, M.Ed., BCBA
Phone: (912)202-5951
Email: smoorhouse@spectrumga.com
Fax 866-467-4321

Amy Mein, Office Manager and Intake Coordinator
Phone: (912)294-4055
Email: amy@spectrumga.com
Fax: 866-467-4321

Website: www.spectrumga.com

CONFIDENTIAL INFORMATION

INTAKE QUESTIONNAIRE

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information, which you think may be helpful in understanding your child. Spectrum of Hope will hold information provided by you as strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

Patient Information	
Child's Name: (first/last):	Parent/Guardian Name(s) and Birth date(s):
Social Security #:	
Date of Birth:	
Street Address:	
Primary Diagnosis:	Diagnosing Physician:
Date of Diagnosis:	Diagnosing Physician Contact #:
Primary Care Physician:	Primary Care Physician Contact #:
Primary Insurance Information	
Insurance Company Name:	
Policy Holder's Name:	Member ID:
Policy Holder's SSN:	Policy Number:
Employer:	Group Number:
Patient's relationship to policy holder:	**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF CARD**
Secondary Insurance Information	
Insurance Company Name:	
Policy Holder's Name:	Member ID:
Policy Holder's SSN:	Policy Number:
Employer:	Group Number:
Patient's relationship to policy holder:	**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF CARD**
Background Information History	
Current Age:	Gender:
Mother's Name:	Father's Name:
Mom's Cell #:	Father's Cell #:
Email:	Email:
Siblings Names and Ages:	
Please explain any other therapies the child receives (speech, OT, etc.) including frequency and intensity of services:	
Medication	
Please list all current medications include dosage (write "none" if child isn't on any medications):	

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Educational Information	
Does your child attend school?	Does he/she have an IEP?
Name of School:	Grade:
Additional Information	
Please describe any behavior issues you are concerned about:	
Please describe your child's current communication skills:	
Please list 5 things that you would like your child to do more often:	
Please list 5 things that you would like your child to do less often:	
What is your availability for ABA therapy? Any other information?:	

CONFIDENTIAL INFORMATION

Confidential Release Form

I, (parent name)_____, do hereby authorize: Spectrum of Hope, LLC., including all employees, to RELEASE TO and OBTAIN FROM information from the record of (child's name)_____,

Date of birth: _____.

The information that may be released includes:

- ☐ Physical Examination
- ☐ Birth Record
- ☐ Medical Examination
- ☐ Psychological Examination
- ☐ Psychosocial History
- ☐ IEP/IFSP
- ☐ Progress Notes
- ☐ Summary of Treatment to Date
- ☐ Discharge Summary
- ☐ After Care Plan
- ☐ Medication Record
- ☐ Education Record

I understand that I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose(s) specified above.
I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance thereon), by written, dated, communication to the Office of Spectrum of Hope, LLC. Fax# 866-467-4321. Office #: 912-294-4055.

_____ _____

Signature of Parent/Guardian Date

CONFIDENTIAL INFORMATION

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI
Your PHI may be used and disclosed by your physician our office staff and others outside of our office that are involved in your care treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a home health agency that provides care with you. For example, your PHI may be provided to a physician to whom you have been referred, to ensure that the BCBA has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for therapy services that may require that your relevant PHI be disclosed to obtain approval for the approved therapy services.

Healthcare Operation: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for the other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law, Public Health Issues as required by law, Communicable Disease, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity and National Security, Workers Compensation, Inmates, Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164,500. Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

CONFIDENTIAL INFORMATION

You may revoke the authorization at any time in writing, except to the extent that your physician or the Physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations.

You may also request that any part of your PHI not be disclosed to a family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices, your request must state the specific restriction requested and to whom you want the restriction to apply.

Consent and Release

I hereby consent to treatment by Spectrum of Hope, LLC, and authorize insurance benefits to be paid directly to Spectrum of Hope, LLC. I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expense associated with the collection of a debt owed to them by me (i.e. Attorney fees, court cost or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

HIPAA and Service Agreement:

Your signature(s) below indicates that you have read the information in this document and agree to be bound by its terms, and that you have received the HIPAA notice form described above or have been offered a copy and declined. Consent by all parents/legal guardians (those with legal custody) is required.

Information Sharing and HIPPA

I give consent to Casey Ayer, as a BCBA for Spectrum of Hope, LLC.to discuss my child's progress and behaviors with any relevant school personnel, speech therapists, occupational therapists, etc. in order to provide the best possible care for my child.

CONFIDENTIALITY, RECORDS, AND RELEASE OF INFORMATION

Services are best provided in an atmosphere of trust. Because trust is so important, all services are confidential except to the extent that you provide us with written authorization to release specified information to specific individuals, or under other conditions and as mandated by Georgia and Federal law and our professional codes of conduct/ethics. These exceptions are discussed below.

TO PROTECT THE CLIENT OR OTHERS FROM HARM

If we have reason to suspect that a minor, elderly, or disabled person is being abused, we are required to report this (and any additional information upon request) to the appropriate state agency. If we believe that a client is threatening serious harm to him/herself or others, we are required to take protective actions which could include notifying the police, and intended victim, a minor's parents, or others who could provide protection, or seeking appropriate hospitalization.

PROFESSIONAL CONSULTATIONS

Behavior Analysts routinely consult about cases with other professionals. In so doing, we make every effort to avoid revealing the identity of our clients, and any consulting professionals are also required to refrain from disclosing any information we reveal to them. We will tell clients about these consultations. If you want us to talk with or release specific information to other professionals with whom you are working, you will first need to sign an Authorization that specifies what information can be released and with whom it can be shared.

CONFIDENTIAL INFORMATION

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep clients' Protected Health Information in one set of professional records. 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 other providers; reports of any professional consultations; billing records; releases; and any reports that have been sent to anyone, including statements for your insurance carrier. Personal notes are taken during supervision sessions. While the contents of 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. These Personal Notes are kept separate from the Clinical Record are not available to you and cannot be sent to anyone else, including the insurance company. Your signature below waives all rights, now and in the future, to accessing these records in any form under any circumstances. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

X_____
(signature of responsible party)

_____
(date)

_____
(witness)

CONFIDENTIAL INFORMATION

Consent for ABA Services

Your signature below indicates that you have received and read the information in this document and agree to Spectrum of Hope's program policies, procedures, and service delivery methods.

I give my consent for ABA services to be implemented by Spectrum of Hope to include assessment and continued therapy services (unless consent is revoked).

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

Authorization To Bill Insurance

I give consent for Spectrum of Hope to bill my or my child's insurance carrier for services rendered. In addition, I agree to pay Spectrum of Hope any deductible or un-covered charge in accordance with my health care plan.

_____ _____

Parent/ Guardian Signature **Date**

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G*]]]]]]]]]]]]]]]]]]]]]]]]]]]]]]] _epcc rm f_tc kw afgjb]]]]]]]]]]]]]]]]]]]]]]]] ct_js_rcb _lb rpc_rcb rfpmsef Qncarps k md Fmnc, G slbcpqr_lb rf_r rfcqc qcptgacq _pc `_qcb ml _l _nnjgcb `cf_tgmp _l_jwqgq &?@?' kmbcj _lb ugjj `c npmtgbcb `w _ npmdcqqgml_j rp_glcb gl ?@?, G slbcpqr_lb rf_r qr_rc j_uq k_w pcosgpc rf_r amldgbclrg_jgrw k_w `c `pmicl slbcp qncagdga agpas k qr_lacq &gd G _k hsbecb rm `c md b_lecp rm qcjd mp mrfcpq* ep_tcjw bgq_`jcb* mp gd rfcpc gq qsqncarcb afgjb _`sqc',

G _jqm slbcpqr_lb rf_r Qncarps k md Fmnc qncag_jgxcq gl rfc ct_js_rgml _lb rpc_rkclr md af_jjclegle `cf_tgmpq _q ucjj _q qigjj _aosgqgrgml npmep_kq* _lb gd Qncarps k md Fmnc gq sl_`jc rm kccr kw n_prgasj_p lccbq* G ugjj `c pcdcppcb rm _l _nnpmnpg_rc _eclaw* glbgtgbs_j* mp mrfcp npmdcqqgml_j,

Qcptgacq8 Qncarps k md Fmnc gknjckclrq ?@? qcptgacq, ? t_pgcrw md rcaflgoscq _pc glrcep_rcb _lb srgjgxcb bspgle rpc_rkclr, Wms ugjj `c clamsp_ecb rm np_argac qigjjq glrpmbsacb gl qcqqgmlq, ? rpc_rkclr nj_l ugrf qncagdga em_jq ugjj `c gknjckclrcb _lb wms _epcc rm gknjckclr gr _q bcqgelcb, Pcam k kclb_rgmlq dmp _bbgrgml_j rpc_rkclr _lb-mp glrclqgtc rpc_rkclr k_w `c k_bc* gd lccbcb, N_pclrq slbcpqr_lb rf_r rfcw _pc pcosgpcb rm `c gltmjtcb gl rpc_rkclr,

_____ _____

Parent/Caregiver Signature Date

Telepractice Services Client Consent

Client Name: _____ Date: _____

Telepractice Services are the use of video conferencing software in lieu of or in addition to face-to-face sessions with a client for one or more Behavioral Health Services.
Times when Telepractice Services may be utilized:

- Behavior Analyst Services
- Parent Training
- Family and/or team meetings
- Staff Supervision

Provision of Telepractice Services

• Telepractice will not replace Registered Behavior Technician (RBT) Services.
• Telepractice will be used in conjunction with face-to-face services and supervision services.
• Your SPECTRUM clinician or local service office may be consulted at any time regarding questions, comments, or concerns.
• Telepractice will not be used for any type of emergency situation and 9-1-1 will always be called.

CLIENT/LEGALLY RESPONSIBLE PERSON

As the: (1) parent or legal guardian of a minor (under 18 years of age); (2) client receiving services if I am my own guardian and it has been determined that I can give consent; or (3) guardian/legally responsible person I acknowledge that I have been advised of the proper utilization of Telepractice Services and have received a copy of this consent. By signing below, I acknowledge that I have had an opportunity to fully discuss the Telepractice Services with my SPECTRUM Clinician and all questions have been answered to my satisfaction. I hereby give consent for Telepractice Services.

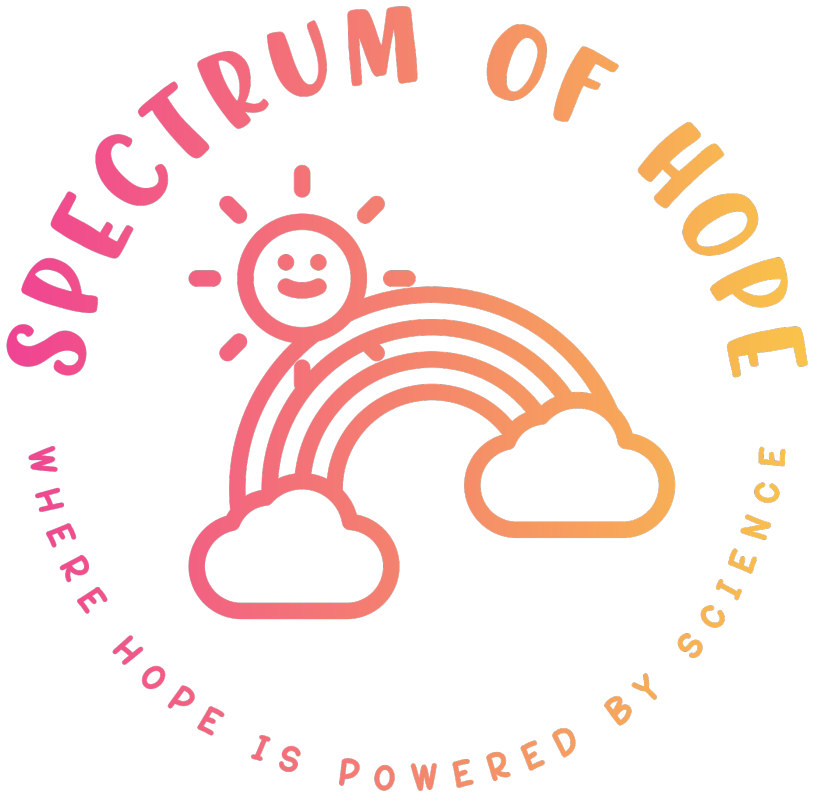
• I or SPECTRUM may withdraw this consent at any time verbally and/or by written notification via electronic or handwritten communication to the office. SPECTRUM will, within a reasonable period of time, offer an alternative
service, if one is available. * If an alternative service is refused, or no alternative is available, SPECTRUM will provide assistance in referring/transitioning the client to another provider if available.

Consenting to Telepractice services is a condition for this client to receive care.

• SPECTRUM of Hope will provide, maintain and retain ownership of the equipment. The equipment should only be used for SPECTRUM Telepractice Services.
• Any recording of a Telepractice service must first be approved via written consent prior to recording and/or use of recording. Telepractice Services are transmitted as per HIPAA compliant software.

• If for any reason an equipment or internet malfunction occurs, a make-up session will be scheduled within an appropriate time frame according to service authorization.

_____	_____	_____
Client/Legal Guardian	Date	Witness



Parent Handbook

Clinical Director: Casey Ayer, MS, BCBA

912-294-4055 www.spectrumga.com

Welcome!

Welcome to Spectrum of Hope. We are so excited to be able to work with you and your family. This information will assist you in gaining an understanding of our program and expectations.

Our Mission

Our Mission is to provide the highest quality and most effective Applied Behavior Analysis therapy. We want to ensure that every child has access to quality care. Educating others, being a positive part of the community, and advocating for the unique needs of each and every family is what we do.

What is ABA?

Applied Behavior Analysis (ABA) is a scientific discipline that utilizes behavioral principles to help individuals make meaningful and socially significant behavior changes. New skills and behaviors are taught while any problematic behaviors are reduced/minimized. Spectrum of Hope uses Board Certified Behavior Analysts (BCBAs) to conduct functional behavior assessments, design behavior support plans, and train staff and family members on how to implement strategies. The goal of Spectrum's ABA program is to teach individuals how to access their environment more effectively, thereby reducing the need to engage in aberrant target behaviors. Spectrum's behavior support plans utilize positive reinforcement strategies, as well as a variety of other proactive measures to motivate individuals during ABA sessions and throughout the ABA program. On-going support, training, and consultation services are available to help service providers and family members maintain treatment gains.

- ABA not only teaches skills but promotes maintenance and generalization of skills. Maintenance is used to determine whether or not the child can skill perform the skill after a given amount of time has passed. Generalization requires that the child not only learns a skill within a structured 1:1 environment, but ensures that the skill transfers to different people, materials, instructions, and environments. Individualized curricula are developed to facilitate learning and develop appropriate programming for each child. Areas that we work on include (but are not limited to):
- Language and functional communication: Communicating needs/wants to others
- Independent Play: Playing without assistance
- Social skills: Interacting with others
- Imitation: Imitating behaviors or vocalizations of others
- Gross/Fine Motor Skills: Control over balance and body movement
- Listener Responding: Attending and responding to spoken words
- Visual/Perceptual Skills: Interpreting things he/she sees visually
- Self-help skills: dressing, grooming, feeding toilet training, etc.

Clinic Schedule

Hours of Operation:
Our clinic is open from 8am to 6pm Monday through Friday. We will be open on some Saturdays. Drop-off and pick-up times are based on which program your child is enrolled. It is important that you strictly adhere to your child's drop-off and pick-up times. Please refer to Spectrum's Cancellation/Late Policy for our policies on tardiness.

Your child should be at the center no later than 5 minutes prior to his/her scheduled start time. Caregiver should arrive 5-10 minutes prior to the end of the session.

Holidays

The clinic will be closed in observance of the following: New Year's Day, Martin Luther King Jr Day, Memorial Day, Independence Day, Labor Day, Veteran's Day, Thanksgiving (the day before and after), and Christmas Break (the week of and the week after Christmas).

Scheduling of Services

Treatment with Spectrum of Hope may involve a large number of service hours. We ask that you work with us on scheduling service times so that your child will receive consistent services. Once we have committed to a particular schedule, we do our best to maintain the appointments on consistent days and times. We ask that you do the same. We cannot change schedules week-to-week or month-to-month. It is very important the treatment is consistent and in-line with treatment recommendations. It is required that clients receive at least 80% of the clinically recommended treatment hours prescribed by the BCBA.

We work hard to accommodate your schedule. However, this is not always possible for several reasons. It is your right to refuse offered services for any reason, including when they conflict with your obligations or if your child will not be alert during sessions. We try our best to work out scheduling in the best interest of everyone but if you refuse appointment times, we cannot guarantee we will have alternate times available. You are welcome to request to be placed on the wait list for preferred appointment times.

Requirements for Treatment

Families must meet one of the two criteria below for acceptance into our treatment program:

1. Families (a) have a child between the ages of 1-18, with (b) one of the medical diagnoses below with an appropriate diagnostic evaluation, report and referral for ABA Therapy:

ICD 10 CM Code	Description
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.3	Other childhood disintegrative disorders
F84.5	Asperger's Syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified

And(c) have insurance coverage for ABA Therapy through Tricare, Anthem/Blue Cross Blue Shield, Georgia Medicaid, Amerigroup, WellCare, PeachState, or CareSource. If you carry any other insurance, we are happy to look into those benefits, but cannot guarantee services.

2. Families (a) have a child age 1-18 and (b) wish to pay for clinic-based ABA Therapy privately. Current fees include (for clients choosing not to use insurance benefits or to pay out of pocket):
    - Initial Intake interview: $125
    - Assessment and Treatment Plan: $500 (every 6 months)
    - 60 minutes, ABA therapy/supervision by BCBA: $125
    - 60 minutes, ABA therapy/supervision by BCaBa or QASP: $75
    - 60 minutes, ABA therapy by RBT: $60

Payment Options

Insurance Coverage:
Spectrum of Hope and its providers are currently contracted through Tricare, Anthem/Blue Cross Blue Shield, Georgia Medicaid, Amerigroup, WellCare, PeachState, and CareSource. We will work with you and your insurance to get the proper authorizations in order to deliver services. We will bill contracted insurance providers for services rendered (subject to applicable deductibles and copayments). However, there is never a guarantee of payment by insurance and it may be required to follow up with them to ensure payment. Sometimes there may be a lapse in services due to authorization issues with the insurance company.

Private Pay

Spectrum of Hope accepts individuals not covered by insurance on a self-pay basis and alternative fee schedule. We can assist in seeking alternative funding that may assist in paying for therapy. There is a list of grants available on the website for Autism Speaks.

Family Involvement

Applied Behavior Analysis (ABA) is outcome-based and focused on making timely progress toward specific treatment goals. All parents/guardians are expected to take part in setting and achieving treatment goals. Providers will share goals, progress, training,

and strategies to work with your child at home and in the community. Your commitment to your child's therapy program is critical to achieving successful results.

Providers may request certain materials or supplies from parents for your child's program. Parents/guardians are expected to fulfill these requests within a timely manner. Please label all belongings provided.
Goals are written with generalization criteria that require children to master skills with parents or guardians. We do this because research shows that parent involvement facilitates generalization of skills across environments and results in best outcomes. In order to demonstrate generalization, it is required that a parent or guardian actively participate in a session at least once per month. Parent training sessions are also available via webcam or in-person. You may schedule by going to www.spectrumga.com and clicking on schedule an appt.

Personal Items to Provide

For each day/session, please provide the following items in your child's backpack:

- Full Day 8am-3pm or 4pm: extra pair of clothes, diapers or pull-ups (if appropriate), extra pairs of underwear (if toilet training), lunch, snack, drink
- AM Only 8am-11am or 12pm: extra pair of clothes, diapers or pull-ups (if appropriate), extra pairs of underwear (if toilet training), snack, drink
- PM Only 12pm-3pm or 4pm: extra pair of clothes, diapers or pull-ups (if appropriate), extra pairs of underwear (if toilet training), snack, drink
- After School 2-6 or 3pm-6pm: extra pair of clothes, diapers or pull-ups (if appropriate), extra pairs of underwear (if toilet training), snack, drink

Pick-up Policy

Only people indicated as authorize persons by the child's parent/guardian may pick-up their child from Spectrum of Hope at the end of the day or session. Please provide a written note if there is any change in who will be picking up your child. We will ask for identification should you list someone who we have not met before and will not release your child to someone without approval.

Cancellation and Late Policy

Spectrum of Hope requires a minimum of 24-hours notice to cancel a session. The 24-hour policy does not include excused absences. Excused absences shall be determined in the sole discretion of Spectrum and may include, but are not limited to sickness, emergencies, or extenuating circumstances. In these circumstances, please call 912-294-4055. Spectrum of Hope reserves the right to require verification of excused absences. Fees are due within 10 days of the invoice. These are not billable to the insurance.

In order to best provide services, Spectrum of Hope adheres to the following fee schedules for our cancellation and late policy:

Situation	Fee
No Call No Show: Any session that does not start within 15 minutes of scheduled time and family has not contacted Spectrum of Hope prior to scheduled time. The session will be cancelled after 15 minutes and an invoice will be sent.	$100
Cancellation: Any session that is cancelled with less than 24 hours' notice.	$50
Late Drop-Off: Family has informed Spectrum of Hope that child will be present but more than 15 minutes late after session start time. If child is more than 30 minutes late (even with phone call) the session will be cancelled.	15+ minutes: $50 30+ minutes: $100
Late Pick-Up: Family picks up child 15 or more minutes after scheduled session end time.	15+ minutes: $50 30+ minutes: $100
Leaving for more than 5 days without 30 days' notice (unless emergency)	$250
If the family is continuously late, then sessions will be rescheduled to better fit the family's schedule. The 15 minutes is a convenience for when families run late from time to time. It's not a daily "window" to get to therapy. Clients are expected to be present at least 5 minutes prior to therapy time so that the provider can be briefed and for transition into the clinic.	

*Fees may be waived in extenuating circumstances (at Spectrum's sole discretion).

No Call-No Show Policy

We pride ourselves in providing effective communication and ask that parents participate in this process. Please make every effort to notify us if you are running late by calling 912-294-4055. We reserve an ABA therapist to work with your child and if we have not been contacted by you about a cancellation or late drop-off, the ABA therapist may no longer be available. One no-call no show may result in termination of services.

Cancellation Policy

Our Health Policy contained herein outlines instances when your child's session should be cancelled due to illness. Additionally, if your ABA therapist arrives at the session and determines that your child is too sick to actively participate, the session will be cancelled. Cancellations due to client illness made by the ABA therapist at the session are considered a cancellation subject to the above fee and will not be made up.

In situations where a family has cancelled their child's sessions 3 or more times in a month, we will call and need to discuss consider rescheduling appointment times. In

extreme circumstances, we may need to consider terminating services due to your insurance provider's policies.

If we have to cancel, except where your child is ill, we will make every effort to make-up the cancelled session. We will do our best to contact you in a timely manner as to any cancellation on our part. We do not guarantee a substitute session for the day the appointment is cancelled and do not make up session that fall on holidays.

Please note: If your child misses (or changes schedule for any other reason) for two or more consecutive weeks, we will be unable to guarantee your session times.

Late Drop-off Policy

Please notify Spectrum of Hope at 912-294-4055 as soon as possible if you know you are going to be dropping your child off late. We reserve your ABA therapist to work with your child. Sessions that begin late due to delays on the part of the family cannot be extended or rescheduled as we cannot guarantee ABA therapist availability at other times. In situations where a family has dropped their child off late 3 or more times in a month, we will call a meeting and need to consider rescheduling appointment times. In extreme circumstances, we may be required to terminate services due to your insurance provider's policies.

Late Pick-up Policy

Please notify Spectrum of Hope at 912-294-4055 as soon as possible if you know you are going to be late to pick up your child. If you anticipate that you will be more than 15 minutes late, it is recommended that you make alternate arrangements for a timely pick up.

At 5 minutes late to pick-up, the provider will call the parent or guardian to assess the situation. If no contact is made by 15 minutes after the scheduled pick-up time, the provider will attempt to make contact with those listed on the authorized pick-up list. If we are unable to confirm an authorized pick-up within 1 hour after pick-up time, the appropriate authorities will be contacted so they can further investigate that situation.

Health and Illness Policy

In order to ensure a healthy environment for clients, families, and staff, sessions should be cancelled if any of the following symptoms are observed:

- Fever
- Chronic cough
- Diarrhea
- Sore throat/strep throat
- Discharge from the eye/pink eye
- Unusual spots or rashes/chickenpox, impetigo, ringworm, hand foot and mouth

- Lethargy/Sleepiness
- Excessive mucus from the nose
- Vomiting
- Head lice
- Any other contagious conditions

If your child displays any of the above symptoms during a therapy session, we will contact you immediately. Parents are responsible for arranging pick-up within an hour. If parent cannot be reached right away, persons from the authorized contact list will be called.

Please notify Spectrum of Hope at 912-294-4055 of any contagious illnesses so we can take appropriate actions to prevent the spread of illness.

Returning to therapy will be based on the following criteria:

- Symptom-free for 24 hours without the use of medication
- 24 hours after the onset of antibiotic treatment (if prescribed)
- A doctor's note ensuring illness is no longer contagious may be required at Spectrum's discretion.

Medical Emergency

In the event of a medical emergency, Spectrum of Hope will contact 911 as well as the child's family. If recommended by EMS, the child will be transported to the closest facility by ambulance.

Medication Administration: Only emergency medication will be administered with proper documentation and training. In the event that emergency medication must be used, 911 will be contacted and then parent. The parent must provide appropriate documentation and emergency medications.

Food/Other allergies: Parent or guardian must provider proper documentation and medication for any life-threatening allergies.

Emergency Guidelines

Building protocols will be followed in the event of an emergency evacuation. Parents will be contacted as soon as possible regarding clinic closure. In the case of emergencies, if public school in the area of service are closed, it is assumed that our clinic is also closed. For instance, if the school is closed due to a weather event, we will more than likely be closed as well.

Termination of Services

Spectrum of Hope may terminate services when:

- It becomes reasonably clear that your child no longer needs the service, is not likely to benefit from further services, and/or has mastered all treatment goals.
- In our sole judgement, anyone at Spectrum (including guests) are threatened or otherwise endangered by parents or another person with whom your child has a relationship and/or a pattern of disrespectful or inappropriate engagements including cursing or derogatory language.
- When you do not pay fees charged or when insurance denied coverage for treatment. In such cases appropriate referrals may be offered. All insurance-related fees are due and payable 30 days from the date of invoice. All fees related to cancellations, late fees, etc. are due within 10 days.
- For excessive tardiness, cancellations, or vacations with or without notice.
- Failure to schedule and attend parent training sessions.
- Inability to contact parent or guardian after intake or inability to secure documents needed to obtain authorization for services.

Termination of Services by Parent/Guardian

You may discontinue treatment at any time. Spectrum will work with your family to make a referral to another provider, if requested. When possible, we request a courtesy 30 days notice in writing so that Spectrum may provide a smooth transition.

Non-discrimination

Spectrum of Hope enrolls individuals on a case-by-case basis with emphasis on the best interest of the child and the ability of the providers. Spectrum does not discriminate on the basis of race religions ethnic origin, gender, age, or disability.

Communication

At Spectrum of Hope we are dedicated to the families we serve; however, we ask that you respect after-work hours and privacy. Please do not call or text BCBAs, RBTs, or other staff unless absolutely necessary. All communication should be directed to the administration team at 912-294-4055 or emailed to amy@spectrumga.com. Please return phone calls, texts, or emails within 24 hours. We use Remind to communicate. You will be provided with the information to sign up.

Grievances

Spectrum of Hope is committed to providing the highest quality ABA services to all families. We are very happy to be working with you and your child in a collaborative way. Should you have any concerns or questions, feel free to contact us at 912-294-4055 or at amy@spectrumga.com.

In the event that you are dissatisfied with any service provided, you are encouraged to communicate your concerns in such a way that the problems may be resolved appropriately. We encourage families to communicate openly with their child's BCBA, and/or our Director, Casey Ayer. Please do not discuss concerns with other staff.

Any problems with your child's individualized program or goals should be directed to your child's BCBA. Any other concerns should be directed to Casey Ayer.

No form of retaliation shall occur, nor shall any barrier to service be created, as a result of a family grievance. All documentation regarding the grievance will be filed in the client's case record.

All staff at Spectrum of Hope adhere to the Code of Ethics of the Behavior Analysis Certification Board, as well as to Georgia laws as they pertain to client-therapist relationships and other areas of ethical concern. Please bring any concerns immediately to the attention of the clinical director, Casey Ayer. Additionally, please be advised that if you have any ethical complaints these may be addressed with the following agencies:

Behavior Analyst Certification Board, Inc.
Disciplinary Matters
1929 Buford Boulevard
Tallahassee, Florida 32308

Frequently Asked Questions

What does an ABA session look like?

A typical ABA session:

- is completely positive
- focuses on skill acquisition and/or behavior reduction
- is individually designed to meet each child's unique needs
- focuses on motivation to learn
- uses the most-effective, evidence-based treatment approach

Individualized Behavior plans focus on:

- working to decrease deficits related to diagnosis, including:
- increasing important, socially significant behaviors
- increasing communication skills including verbal behavior and social skills
- increasing play behaviors
- increasing self-help and adaptive skills increasing skills so that the child can interact with and function as same-age peers
- decreasing behaviors that impede the ability to learn

The standard therapy hour consists of 45-50 minutes of direct contact with the client and 10-15 minutes devoted to required record-keeping and other administrative duties. It usually takes 10-15 minutes to arrange the materials and set up for sessions prior to engaging with the client. It also takes about 10-15 minutes at the end of the session to record data, take notes, tidy the setting, and discuss the session and/or

answer questions with parents. Staff are also expected to review session with parents at the end of the session.
*If sessions occur at home, a parent/guardian's presence is required at all times.

What does the process look like for accessing services?

1. A functional behavior assessment (FBA) will be conducted by a BCBA and is a process for identifying the purpose or function of target behaviors. The BCBA gathers data, conducts interviews, and directly observes the individual's behaviors during the assessment period. A skills assessment is also completed to identify skill repertoire. Information gathered will be presented in the behavior support plan. The assessment process generally takes 4-6 weeks from the time the intake paperwork is turned in. If the BCBA is unable to establish initial contact within 2 weeks of the enrollment due to lack of response, then services will not move forward. If paperwork is not turned in with the intake (assessments, evaluations, referrals, etc.), then services will not move forward.

2. Information gathered from the FBA and skills assessment will be then used to design a behavior support plan. The plan will objectively define target and skill acquisition behaviors, describe the function of behaviors, identify treatment goals and objectives, and outline antecedent and consequence-based strategies. The behavior support plan will guide staff and parents on how to interact with the individual in a way to occasion positive and appropriate behaviors, as well as how to respond in the event that target behaviors occur.

3.The BCBA will then present the plan to the parent/guardian and obtain consent to implement the plan. The BCBA will then train staff and family members on how to effectively implement all procedures outlined in the plan.

4. The BCBA and support staff will provide consultation services to ensure that the strategies are being implemented with consistency and to address any questions or concerns that come up during the treatment process.

5. The BCBA will obtain data taken by support staff to review. The BCBA will analyze the data to evaluate the effectiveness of the intervention and will make revisions, if necessary, to ensure progress toward treatment goals are being achieved. Treatment plans are updated every 6 months.

What services do you offer?

Spectrum of Hope uses Applied Behavior Analysis (ABA) as an instructional method to teach children. ABA is an evidence-based, data-driven approach that has become widely accepted as an effective treatment for individuals diagnosed with Autism Spectrum Disorder. Spectrum of Hope utilizes the following evidence-based methods in treatment:

Antecedent Based Intervention

Antecedent-based intervention (ABI) is an evidence-based practice used to address both interfering and on-task behaviors. This practice is most often used after a functional behavior assessment (FBA) has been conducted to identify the function of the interfering behavior.

DESCRIPTION

ABIs are a collection of strategies in which environmental modifications are used to change the conditions in a setting that prompt a learner with ASD to engage in an interfering behavior. For example, many interfering behaviors continue to occur because the environmental conditions in a particular setting have become linked to the behavior over time. The goal of ABI is to identify factors that reinforce the interfering behavior and then modify the environment or activity so that the factor no longer elicits the interfering behavior. Common ABI procedures include 1) using highly preferred activities/items to increase interest level; 2) changing the schedule/routine 3) implementing pre-activity interventions (e.g., providing a warning about the next activity, providing information about schedule changes); 4) offering choices 5)altering the manner in which instruction is provided 6) enriching the environment so that learners with ASD have access to sensory stimulation that serve the same function as the interfering behavior (e.g., clay to play with during class, toys/objects that require motor manipulation). ABI strategies often are used in conjunction with other evidence-based practices such as functional communication training, extinction, and reinforcement (Neitzel, 2009).

Differential Reinforcement

Differential reinforcement of alternative, incompatible, or other behavior (DRA/I/O) teaches new skills and improves behavior by providing positive/desirable consequences for preferred behaviors. Differentially reinforcing an alternative behavior (DRA) occurs when the problem behavior is absent; the adult then provides positive reinforcers for the desired behavior. DRA is used when behaviors interfere with the learner's learning, development, relationships, health, and so on (e.g., tantrums, aggression, self-injury, stereotypic behavior).

Differential reinforcement of other behaviors means that reinforcement is provided for desired behaviors, while inappropriate behaviors are ignored. Differential reinforcement (DR) is a special application of reinforcement designed to reduce the occurrence of inappropriate or interfering behaviors (e.g., tantrums, aggression, self-injury, stereotypic behavior).

Through differential reinforcement, desired behaviors are reinforced for the learner, while inappropriate behaviors are ignored. Reinforcement is provided when: a) the learner is engaging in a specific desired behavior other than the inappropriate behavior (DRA), b) the learner is engaging in a behavior that is physically impossible to do while exhibiting the inappropriate behavior (DRI), or c) the learner is not engaging in the interfering behavior (DRO). Differential reinforcement is often used with other evidence-based practices such as prompting to teach the learner behaviors that are more functional or incompatible with the interfering behavior, with the overall goal of decreasing that interfering behavior.

DRA/I/O meets evidence-based criteria with 26 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to young adults (19–22 years) with ASD. DRA/I/O can be used effectively to address social, communication, behavior, joint attention, play, school-readiness, academic, motor, and adaptive skills.

Social Skills Training

Social skills training (SST) is a form of group or individual instruction designed to teach learners with autism spectrum disorders (ASD) ways to appropriately interact with peers, adults, and other individuals.

DESCRIPTION

Social skills training (SST) is a form of group or individual instruction designed to teach learners with autism spectrum disorders (ASD) ways to appropriately interact with peers, adults, and other individuals. Most social skill meetings include instruction on basic concepts, role-playing or practice, and feedback to help learners with ASD acquire and practice communication, play, or social skills to promote positive interactions with peers.

SST meets evidence-based criteria with 7 group design and 8 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to young adults (19–22 years) with ASD. SST can be used effectively to address social, communication, behavior, play, and cognitive skills.

Assistive Technology

Assistive technology (AT) refers to equipment that is used by an individual with a disability to increase his or her functional capabilities. Many students with autism require strategies, equipment, and/or support to reach their potential (Schlosser, Blischak, Belfiore, Bartley, & Barnett, 1998). Research has shown that one such means of support, assistive technology, is effective for students with autism spectrum disorder.

DESCRIPTION

According to the IDEA Amendment (2004), assistive technology (AT) is a broad term used to describe any item, piece of equipment, or product system that is used "to increase, maintain or improve the functional capability of a child with a disability." Furthermore, IDEA recognized that AT is a critical instrument in meeting the educational and overall developmental needs of students with disabilities in school (Smith, Murphy-Herd, Alvarado, & Glennon, 2005). AT devices can be electronic or non-

electronic. Three main types of AT, ranging from “low” and “mid” to “high” technology, can be used with learners with autism. Each type is described below.

- “Low” technology. These strategies do not involve any type of electronic or battery-operated device. Such strategies typically include low-cost and easy-to-use equipment, such as dry-erase boards, clipboards, laminated photographs, photo albums, three-ring binders, Picture Exchange Communication System (PECS), etc. The strategies can be used to enhance expressive and receptive communication skills with autism.
- “Mid” technology. These strategies use battery-operated devices or basic/simple electronic devices. Examples of “mid” technology devices are tape recorders, voice output devices, timers, and calculators. They are primarily used as a means to support expressive communication and enhance classroom participation, focus attention on various skill areas, and assist in the development of social skills.
- “High” technology. These strategies are complex technological support strategies. They typically involve high-cost equipment such as computers and adaptive hardware (e.g., touch window, software, trackballs), accessory equipment (e.g., digital cameras, scanners), video cameras, and complex voice output devices.

It is essential to carefully train educators and learner on the use of AT devices to ensure that they are used correctly. When needed, AT should be incorporated into every aspect of daily living in order to improve the functional capabilities of learners with autism. Thus, it is important to consider that all AT devices, from “low” technology to “high” technology, should always be individualized to meet the unique needs of any learner with autism. Most important, the optimal goal of AT strategies is to increase the learner’s independent functioning skills by decreasing the amount of direct support needed from another person.

Picture Exchange Communication System (PECS)

The Picture Exchange Communication System (PECS) is used to teach learners to communicate in a social context

DESCRIPTION

The PECS system is primarily used to help individuals who have difficulty speaking use a picture-based system as an aided-AAC system. Researchers have used PECS-based methods to improve communication, play, and behavioral skills (Ganz et al., 2013). Using PECS, learners are initially taught to give a picture of a desired item to a communicative partner in exchange for the item. There are six phases of PECS instruction: (1) “how” to communicate, (2) distance and persistence, (3) picture discrimination, (4) sentence structure, (5) responsive requesting, and (6) commenting.

PECS meets evidence-based criteria with 2 group design and 4 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to middle school-age learners (12–14 years) with ASD. PECS can be used effectively to address social, communication, and joint attention skills.

Peer-Mediated Instruction and Intervention (PMII)

As a way to improve social reciprocity in more natural social contexts, peer-mediated interventions are used to provide social learning opportunities through peer interaction, peer modeling, and peer reinforcement.

DESCRIPTION

Over the years, social skills training has been emphasized in the school setting for helping students with autism (AU). Many of these students learn their interactional skills through adult direction. Peer-mediated instruction and interventions (PMII) emphasize the involvement of typically developing peers as socially competent facilitators to promote appropriate communicative and social behaviors. Peer-mediated interventions encompass various teaching strategies. DiSalvo and Oswald (2002) have organized peer-mediated interventions into three approaches according to peer expectancies to promote interaction: (a) manipulation of the situation or contingencies, (b) peer instruction in social interaction strategies, and (c) instruction of the target child in initiation strategies. The first approach encourages students with autism to interact with peers by creating learning and modeling opportunities. The second aims at teaching the typically developing peer specific social skill strategies to enhance social interaction with students with autism. Finally, the third approach increases peer effectiveness by teaching students with autism initiation skills. Peer-mediated interventions usually take place in the classroom or in the community. The child’s natural social environment is most preferable. In addition, it is important to establish peers’ positive attitude toward the student with autism and to create a supportive environment for social interaction.

PMII meets evidence-based criteria with 15 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to high school-age learners (15–18 years) with ASD. PMII can be used effectively to address social, communication, joint attention, play, school readiness, and academic skills.

Pivotal Response Training (PRT)

Pivotal Response Training (PRT) is a contemporary naturalistic-behavioral intervention that applies principles of applied behavior analysis (ABA) to build on learner initiative and interests, enhancing the pivotal learning variables: motivation, responding to multiple cues, self-management, and self-initiations of social interactions.

DESCRIPTION

Pivotal Response Training (PRT) is a contemporary naturalistic-behavioral intervention that applies principles of applied behavior analysis (ABA) to teach learners with autism spectrum disorders (ASD). PRT builds on learner initiative and interests; it is particularly effective for developing communication, language, play, and social behaviors. PRT was developed to create a more efficient and effective intervention by enhancing four pivotal learning variables: motivation, responding to multiple cues,

self-management, and self-initiations. According to theory, these skills are pivotal because they are the foundational skills upon which learners with ASD can make widespread and generalized improvements in many other areas.
PRT meets evidence-based criteria with one group design and 7 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to middle school-age learners (12–14 years) with ASD. PRT can be used effectively to address social, communication, joint attention, and play skills.

Structured Play Group

Structured play groups (SPG) involve small-group activities characterized by their occurrences in a defined area and with a defined activity; the specific selection of typically developing peers to be in the group; and a clear delineation of theme and roles by adult leading, prompting, or scaffolding as needed to support students' performance related to the goals of the activity.

DESCRIPTION

Structured play groups (SPG) are interventions using small groups to teach a broad range
of outcomes. SPG activities are characterized by their occurrences in a defined area and with a defined activity; specific selection of typically developing peers to be in the group; and clear delineation of theme and roles by adult leading, prompting, or scaffolding as needed to support the learners' performance related to the goals of the activity.
SPG meets evidence-based criteria with 2 group design and 2 single case design studies. According to the evidence-based studies, this intervention has been effective for elementary school-age learners (6-11 years) with ASD. SPG can be used effectively to address social, communication, behavior, play, school-readiness, and academic skills .

Naturalistic Intervention

Naturalistic intervention (NI) is a collection of practices designed to encourage specific target behaviors based on learners' interests. It occurs within the typical settings, activities, and/or routines in which the learner participates.

DESCRIPTION

Naturalistic intervention (NI) is a collection of practices including environmental arrangement, interaction techniques, and strategies based on applied behavior analysis principles. These practices are designed to encourage specific target behaviors based on learners' interests by building more complex skills that are naturally reinforcing and appropriate to the interaction. Naturalistic intervention occurs within typical settings, activities, and/or routines in which the learner participates.
NI meets evidence-based criteria with 10 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to elementary school-age learners (6–11 years) with ASD. NI can be used effectively to address social, communication, behavior, joint attention, play, and academic skills.

Response Interruption/Redirection (RIR)

Response interruption/redirection (RIR) involves the introduction of a prompt, comment, or other distractors when an interfering behavior is occurring. The distractor is designed to divert the learner's attention away from the interfering behavior and results in its reduction.

DESCRIPTION

Response interruption/redirection (RIR) is predominantly used to address behaviors that are repetitive, stereotypical, and/or self-injurious. RIR often is implemented after a functional behavior assessment (FBA) has been conducted to identify the function of the interfering behavior. RIR is particularly useful with persistent interfering behaviors that occur in the absence of other people, in a number of different settings, and during a variety of tasks. These behaviors often are not maintained by attention or escape. Instead, they are more likely maintained by sensory reinforcement and are often resistant to intervention attempts. RIR is particularly effective with sensory-maintained behaviors because learners are interrupted from engaging in interfering behaviors and redirected to more appropriate, alternative behaviors.
RIR meets evidence-based criteria with 10 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to young adults (19–22 years) with ASD. RIR can be used effectively to address social, communication, behavior, play, school-readiness, and adaptive skills.

Functional Communication Training (FCT)

Functional communication training (FCT) is a positive behavior support (PBS) intervention designed to reduce problem behaviors by replacing them with meaningful or functional communication, whether verbal or gestural. The emphasis of the communication is on functionality as opposed to form.

DESCRIPTION

Functional communication training (FCT) emerged from the literature on functional behavioral assessment (FBA) as a systematic practice to replace inappropriate behavior or subtle communicative acts with more appropriate and effective communicative behaviors or skills. FCT is always implemented after an FBA has been conducted to identify the function of an interfering behavior. When using FCT, teachers/practitioners analyze the interfering behavior to determine what the learner is trying to communicate. For example, is the learner biting peers when she wants a toy that another child has? Or is the learner yelling in class so that he will be sent out of the room? After teachers/practitioners have identified the function of the interfering behavior, they then implement FCT to identify and teach a replacement behavior that is easy for the learner to use and serves the same purpose as the interfering behavior, but in a more appropriate way (Frazone, 2009).

FBA meets evidence-based criteria with 10 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to young adults (19–22 years) with ASD. FBA can be used effectively to address communication, behavior, school-readiness, academic, and adaptive skills.

Scripting

Scripting (SC) involves creating a verbal and/or written description about a specific skill or situation that serves as a model for the learner. Scripts are usually practiced repeatedly before the skill is used in the actual situation.

DESCRIPTION

Scripting (SC) involves presenting learners with a verbal and/or written description about a specific skill or situation that serves as a model for the learner. SC is intended to help learners anticipate what may occur during a given activity and improve their ability to appropriately participate in the activity. The scripts are practiced repeatedly before the skill is used in the actual situation. When learners are able to use the scripts successfully in actual situations, the script should be systematically faded. SC is often used in conjunction with modeling, prompting, and reinforcement.

Social scripts include written sentences or paragraphs that students with ASD can use in across settings and situations. Research has demonstrated that social scripts and enhance the social interactions, communication, and various other behaviors of those with ASD, especially when they have limited expressive language. Learners who have difficulties in initiating communication or generating language under stress can also benefit from social scripts. In such cases, the learner memorizes the social script and learns when and how to use it appropriately. Social scripts can be taught through modeling, prompting, and reinforcement.

According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to high school-age learners (15–18 years) with ASD. SC can be used effectively to address social, communication, joint attention, play, cognitive, school-readiness, and vocational skills (Cox, 2013).

Parent-Implemented Intervention

Parent-implemented Intervention (PII) entails parents directly using individualized intervention practices with their child to increase positive learning opportunities and acquisition of important skills. Parents learn to implement such practices in their home and/or community through a structured parent training program.

DESCRIPTION

Parent-implemented intervention (PII) includes programs in which parents are responsible for carrying out some or all of the intervention(s) with their own child. Parents are trained by professionals one-on-one or in group formats in home or community settings. Methods for training parents vary, but may include didactic instruction, discussions, modeling, coaching, or performance feedback. Parents may be trained to teach their child new skills, such as communication, play, or self-help, and/or to decrease challenging behavior. Once parents are trained, they proceed to implement all or part of the intervention(s) with their child.

PII meets evidence-based criteria with 8 group design and 12 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to elementary school-age learners (6–11 years) with ASD. PII can be used effectively to address social, communication, behavior, joint attention, play, cognitive, school-readiness, academic, and adaptive skills.

Task Analysis

Task analysis (TA) is the process of breaking a skill into smaller, more manageable steps in order to teach the skill.

DESCRIPTION

Task analysis (TA) is the process of breaking a skill into smaller, more manageable steps in order to teach the skill. The learner can be taught to perform individual steps of the chain until the entire skill is mastered (also called “chaining”). Other practices, such as reinforcement, video modeling, or time delay, should also be used to facilitate learning the smaller steps. As the smaller steps are mastered, the learner becomes more and more independent in his or her ability to perform the larger skill.

TA meets evidence-based criteria with 8 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (age 3–5 years) to middle school-age learners (12–14 years) with ASD. TA can be used effectively to address social, communication, joint attention, academic, motor, and adaptive skills.

Technology-Aided Instruction and Innovation

Technology- Aided Instruction and Innovation (TAII) involves instruction or interventions in which technology is the central feature supporting the acquisition of a goal for the learner.

DESCRIPTION

Technology-aided instruction and innovation (TAII) was previously called Computer-Aided Instruction and Speech Generating Devices in the National Professional Development Center on Autism Spectrum Disorders 2009 report. Technology is defined as “any electronic item/equipment/application or virtual network that is used intentionally to increase/maintain and/or improve daily living, work/productivity, and recreation/leisure capabilities of adolescents with autism spectrum disorders” (Odom et al., 2013). TAII are those in which technology is the central feature of an intervention that supports a goal or outcome for the learner. Technology is defined as “any electronic item/equipment/application or virtual network that is used intentionally to increase/maintain and/or improve daily living, work/productivity, and recreation/leisure capabilities of adolescents with autism spectrum disorders” (Odom et al., 2013). TAII incorporates a broad range of devices, such as speech-generating devices, smartphones, tablets, computed-assisted instructional programs, and virtual networks. The common features of these

interventions are the technology itself (as noted) and instructional procedures for learning to use the technology or supporting its use in appropriate contexts (Odom, 2013).

TAII meets evidence-based criteria with 9 group design and 11 single case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to young adults (19–22 years) with ASD. TAII can be used effectively to address social, communication, behavior, joint attention, cognitive, school-readiness, academic, motor, adaptive, and vocational skills.

Activity-Based Intervention

Activity-based intervention (ABI) provides a developmentally appropriate framework for incorporating several effective instructional strategies into a child's daily activities. This approach is a promising way to utilize naturally occurring antecedents and consequences to teach children with autism target skills.

DESCRIPTION

Activity-based intervention (ABI) originated with Diane Bricker and her colleagues at the University of Oregon. It is defined as a "child-directed, transactional approach that embeds intervention on children's individual goals and objectives in routine, planned, or child-initiated activities, and uses logically occurring antecedents and consequences to develop functional and generative skills" (Bricker & Cripe, 1992, p. 40).

Novick (1993) described ABI as a "combination of selected strategies found in early childhood and behavior analytic approaches and shares many theoretical and philosophical underpinnings with developmentally appropriate practice" (p. 405). It is considered a naturalistic teaching approach and is commonly described in terms of embedded instruction, routine-based intervention, or integrated therapy (Pretti-Frontczak, Barr, Macy, & Carter, 2003).

ABI evolved as part of a linked system that moves from assessment to goal development to intervention, through evaluation (Bricker & Cripe, 1992). A child-directed approach, it emphasizes following the child's interest and actions. Four sequential key elements make up ABI: (a) the use of routine, planned, or child initiated-activities; (b) the embedding of goals and objectives in routine, planned, or child-initiated activities; (c) the use of logical antecedents and consequences; and (d) the selection of target skills that are generative and functional.

Bricker, Pretti-Frontczak, and McComas (1998) suggested a five-step process of selecting appropriate skills for intervention:

1. Administer comprehensive curriculum-based assessment/evaluation tools.
2. Summarize the results of the assessment in terms of interests, strengths, and needs.
3. Target skills that are (a) functional, (b) usable across settings with different people and materials, (c) observable and measurable, and (d) part of the child's natural daily environment.
4. Identify appropriate goals and objectives through prioritizing skills.
5. Develop written goals and objectives that are observable, measurable, and clearly understandable to team members.

Two intervention criteria must be met in order for progress to occur: (a) goals and objectives must be addressed during developmentally appropriate activities, and (b) repeated opportunities for practicing targeted skills must be provided during these activities (Bricker et al., 1998).

Visual Support

Children with ASD often have superior visual-spatial skills and poor auditory memory skills. Visual supports (VS) provide concrete supports utilizing the strength in visual processing (Rollins, 2014).

DESCRIPTION

Visual supports (VS) are concrete cues that provide information about an activity, routine, or expectation; they may also support skill demonstration. Visual supports can provide assistance across activities and settings, and can take on a number of forms and functions. These include but are not limited to: photographs, icons, drawings, written words, objects, environmental arrangement, schedules, graphic organizers, organizational systems, and scripts. Visual supports are commonly used to: 1) organize learning environments; 2) establish expectations around activities, routines, or behaviors (e.g., visual schedules, visual instructions, structured work systems, scripts, power cards); 3) provide cues or reminders (e.g., conversation and initiation cues, choice making supports, visual timers, finished box); and 4) provide preparation or instruction (e.g., video priming, video feedback).

Visual supports meet evidence-based criteria with 18 single case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to young adults (19–22 years) with ASD. Visual supports can be used effectively to address social, communication, behavior, play, cognitive, school-readiness, academic, motor, and adaptive skills.

Extinction

Extinction refers to an applied behavior analysis (ABA) procedure whereby a behavior that was formerly reinforced is no longer reinforced.

DESCRIPTION

Extinction can occur when teachers withhold identified reinforcers for a target behavior that was previously reinforced. This strategy is used to reduce or eliminate a challenging behavior. The extinction procedure relies on accurately identifying the function of the behavior and the consequences, or responses to the target behavior, which may be reinforcing its occurrence. The consequence that is believed to reinforce the occurrence of the target challenging behavior is removed or withdrawn, resulting in a decrease of the target behavior. An initial increase in the challenging behavior (often called an "extinction burst") is common before the behavior is eventually extinguished. Extinction should not be used in isolation. Other practices that are often used in combination with extinction include differential reinforcement and functional behavior assessment.

EXT meets evidence-based criteria with 11 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to high school-age learners (15–18 years) with ASD. EXT can be used effectively to address communication, behavior, school-readiness, and adaptive skills.

Modeling

Modeling is the demonstration of a desired target behavior that results in imitation of the behavior by the learner and that leads to the acquisition of the imitated behavior. This EBP is often combined with other strategies such as prompting and reinforcement.

DESCRIPTION

Modeling (MD) occurs when an individual demonstrates a skill or exhibits a behavior after observing it from a performance by a model. Modeling is often referred to as in vivo or live modeling, to differentiate it from video modeling.

MD meets evidence-based criteria with 1 group design and 4 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to young adults (19–22 years) with ASD. MD can be used effectively to address social, communication, joint attention, play, school-readiness, academic, and vocational skills.

Discrete Trial Training

Discrete trial training (DTT) is a one-to-one instructional approach used to teach skills in a planned, controlled, and systematic manner. DTT is used when a learner needs to learn a skill best taught in small, repeated steps. In addition, DTT is often characterized by repeated, or massed, trials that have a definite beginning and end.

DESCRIPTION

Each trial or teaching opportunity has a definite beginning and end, thus the “discrete trial” descriptor. Within DTT, the use of antecedents and consequences is carefully planned and implemented. The instructional trial begins when the adult presents a clear direction or stimulus, which elicits a target behavior. Positive praise and/or tangible rewards are used to reinforce desired skills or target behaviors. Data collection is an important part of DTT and supports decision making by providing teachers/practitioners with information about beginning skill level, progress and challenges, skill acquisition and maintenance, and generalization of learned skills or behaviors. Other practices that are used in DTT include task analysis, prompting, time delay, and reinforcement.

DTT meets evidence-based criteria with 13 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to elementary school-age learners (6–11 years) with ASD. DTT can be used effectively to address social, communication, behavior, joint attention, school-readiness, academic, adaptive, and vocational skills.

Video Modeling

Video modeling (VM) is a mode of teaching that uses video recording and display equipment to provide a visual model of the targeted behavior or skill.

DESCRIPTION

In video modeling (VM), the model is shown to the learner, who then has an opportunity to perform the target behavior, either in the moment or at a later point in time. Types of video modeling include basic video modeling, video self-modeling, point-of-view video modeling, and video prompting. Basic video modeling is the most common and involves recording someone other than the learner engaging in the target behavior or skill. Video self-modeling is used to record the learner displaying the target skill or behavior and may involve editing to remove adult prompts. Point-of-view video modeling is when the target behavior or skill is recorded from the perspective of what the learner will see when he or she performs the response. Video prompting involves breaking the behavior into steps and recording each step with incorporated pauses during which the learner may view and then attempt a step before viewing and attempting subsequent steps. Video prompting can be implemented with other, self, or point-of-view models. Video modeling strategies have been used in isolation and also in conjunction with other intervention components such as prompting and reinforcement strategies.

VM meets evidence-based criteria with one group design and 31 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to young adults (19–22) years with ASD. VM can be used effectively to address social, communication, behavior, joint attention, play, cognitive, school-readiness, academic, motor, adaptive, and vocational skills.

Prompting

Prompting (PP) procedures include any help given to learners that assists them in using a specific skill.

DESCRIPTION

Prompting is used to increase the likelihood that a person will provide a target response. When using a prompt to enhance learning a specific skill, it is important to fade, or reduce, the prompt once the skill is mastered (Alberto & Troutman, 2013). Verbal, gestural, or physical assistance is given to learners to assist them in acquiring or engaging in a targeted behavior or skill. Prompts are generally given by an adult or peer before or as a learner attempts to use a skill. These procedures are often used in conjunction with other evidence-based practices including time delay and reinforcement or are part of protocols for the use of other evidence-based practices such as pivotal response training, discrete trial teaching, and video modeling. Thus, prompting procedures are considered foundational to the use of many other evidence-based practices.

PP meets evidence-based criteria with one group design and 32 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to young adults (19–22 years) with ASD. PP can be used

effectively to address social, communication, behavior, joint attention, play, school-readiness, academic, motor, adaptive, and vocational skills.

Prompts are often categorized into a hierarchy from most intrusive to least intrusive. Types of prompts (from most intrusive to least intrusive), their descriptions, and examples are as follows:

- *Full physical assistance*: The teacher uses "hand-over-hand" support to aid the child in completing a task (e.g., when teaching the child to pick up a cup, the teacher takes the child's hand and guides him to pick it up).
- *Partial physical assistance*: The teacher provides partial physical assistance to help the child complete a task (e.g., when teaching the child to pick up the cup, the teacher guides the child's hand to the cup by tapping his elbow).
- *Full model:* The teacher models the desired behavior (e.g., when teaching the child how to clap, the teacher claps while telling the child to clap).
- *Partial model*: The teacher models only part of the desired behavior (e.g., when teaching the child how to clap, the teacher puts his hands in front of himself, but does not actually clap).
- *Full verbal prompts*: The teacher verbally models the desired behavior (e.g., when teaching the child to expressively label "car," the teacher asks, "What is it? Say car.").
- *Partial verbal model*: The teacher verbally models only part of the desired behavior (e.g., when teaching the child to expressively label "car," the teacher asks, "What is it? Say c___").
- *Gestural prompt:*. The teacher utilizes a physical gesture to encourage the desired behavior (e.g., when teaching the function of an object, the teacher says, "What do you drink with?" while holding his hand to his mouth shaping it like a cup).
- *Positional prompt*: The teacher places the target item in a location that is closer to the child (e.g., when teaching the child to label "toy," the teacher places the toy closest to the child).
- *Time-delay or prompt-delay techniques* (Walker, 2008): This instructional procedure is proven to be effective, especially for children with ASD. When teaching a novel task, time delay is used to transfer the stimulus control from a controlling prompt to a natural prompt by placing varying amounts of time between a controlling prompt and a natural prompt. Given different lengths of time delay, time delay strategies are categorized into constant time delay (CTD) and progressive time delay (PTD). CTD indicates that there is a standard time delay whereas PTD has a graduated delay. The procedures of time delay strategy begin with a zero-second (0-s) delay trial, meaning the controlling prompt is presented with task instruction at the same time without any delay in between. Gradually, to fade the prompt, time delay is increased between the natural prompt (task direction) and the controlling prompt.

Not all prompts in the hierarchy need to be used when teaching a skill. Prompts should be chosen based on which ones are most effective for a particular child. Prompts should be faded systematically and as quickly as possible to avoid prompt dependency. Overall, the goal of using prompts is to help the child independently perform the desired behavior.

Reinforcement

Reinforcement (R+) is used to teach new skills and to increase behaviors. Reinforcement establishes the relationship between the learner's behavior/use of skill and the consequence of that behavior/skill.

DESCRIPTION

Reinforcement (R+) is a term used in operant conditioning that refers to a relationship between a response and a stimulus change. Reinforcement occurs when a stimulus change immediately follows a response and increases the future frequency of that type of behavior in similar conditions. The stimulus may include a change in the environment, a social interaction with another person (e.g., a greeting, praise), access to a favored item, or many other types of change. The relationship between these two conditions is only reinforcing if the consequence (or stimulus change) increases the likelihood that the learner performs that behavior/skill (response).

Reinforcement can be positive or negative. *Positive reinforcement* is the delivery of a reinforcer (i.e., something that the learner desires which may be tangible, edible, activity-based, interest-based, and so on) after the learner performs the target skill or behavior. Positive reinforcement can also be implemented in the format of a token economy program. Token economy programs systematically give learners access to tokens when targeted behaviors/skills are demonstrated by the learner. These tokens are exchanged for desired objects or activities that reinforce the learners' use of that behavior/skill. *Negative reinforcement* is the removal of an object or activity that the learner does not want (e.g., taking a break after finishing a set of math problems) when the learner does the identified behavior or skill.

Reinforcement is a foundational evidence-based practice and is almost always used in conjunction with other evidence-based practices (e.g., prompting, pivotal response training, discrete trial teaching, functional communication training).

Reinforcement meets evidence-based criteria with 43 single-case design studies. According to the evidence-based studies, this intervention has been effective for toddlers (0–2 years) to young adults (19–22 years) with ASD. Reinforcement can be used effectively to address social, communication, behavior, joint attention, play, cognitive, school-readiness, academic, motor, adaptive, and vocational skills.

Time Delay

Time delay (TD) is a practice that focuses on systematically fading the use of prompts during instructional activities.

DESCRIPTION

With the time delay (TD) procedure, a brief delay is provided between the initial instruction and any additional instructions or prompts. The evidence-based research focuses on two types of time delay procedures: progressive and constant. With progressive time delay, the adult gradually increases the waiting time between an instruction and any prompts that might be used to elicit a response from a learner with ASD. For example, a teacher provides a prompt immediately after an instruction when a learner with ASD is initially learning a skill. As the learner becomes more proficient at using the skill, the teacher gradually increases the waiting time between the instruction and the prompt. In constant time delay, a fixed amount of time is always used between the instruction and the prompt as the learner becomes more proficient at using the new skill. Time delay is always used in conjunction with a prompting procedure (e.g., least-to-most prompting, simultaneous prompting, graduated guidance).

TD meets evidence-based criteria with 12 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to young adults (19–22 years) with ASD. TD can be used effectively to address social, communication, behavior, joint attention, play, cognitive, school-readiness, academic, motor, and adaptive skills.

Functional Behavior Assessment (FBA)

Functional behavior assessment (FBA) is a systematic set of strategies used to determine the underlying function or purpose of a behavior so that an effective intervention plan can be developed.

DESCRIPTION

FBA consists of describing the interfering or problem behavior, identifying antecedent or consequent events that control the behavior, developing a hypothesis regarding the behavior, and testing that hypothesis. Data collection is an important part of the FBA process. FBA is typically used to identify the causes of interfering behaviors such as self-injury, aggression towards others, or destructive behaviors and is usually followed by the creation and implementation of a behavior package to address the interfering behavior described. Often, teachers/practitioners use functional communication training (FCT), differential reinforcement, response interruption/redirection, extinction, and stimulus control/environmental modification to address these behaviors in learners with ASD.

FBA meets evidence-based criteria with 10 single-case design studies. According to the evidence-based studies, this intervention has been effective for preschoolers (3–5 years) to elementary and secondary school-age learners (6–22 years) with ASD. FBA can be used effectively to address communication, behavior, school-readiness, academic, and adaptive skills.

In addition to using an evidence-based, data driven approach to learning (ABA), Spectrum of Hope incorporates curricula that have a track record of (a) providing a useful assessment (e.g., starting point) for teaching skills, and (b) clearly outline a progression of skills that helps a learner achieve a peer-age repertoire. These evidence-based curricula include, but are not limited to:

1. The Verbal Behavior Milestones Assessment and Placement Program (The VB-MAPP).
   The VB-MAPP is an evidence based assessment tool, curriculum guide, and skill tracking system that is designed for children with autism who demonstrate language delays (Sundberg, M. L., 2008).
2. Skillstreaming (social skills curriculum)
   Skillstreaming is an evidence-based prosocial skills training program that consists of an assessment tool, curriculum guide, and skill tracking system and is designed for early childhood through adolescence (Goldstein, A.P. & McGinnis, E., 2001).
3. Essentials for Living
   The Essential for Living is an evidence based functional skills curriculum and assessment, skill tracking instrument for children and adults with moderate to severe disabilities or limited skill repertories (McGreevy, P. A., 2012).
4. Assessment of Functional Living Skills (AFLS)
   The AFLS is an evidence based assessment tool, curriculum guide, and skills-tracking system used to help guide the instruction of functional living skills. The

AFLS is comprised of the following modules: Basic Living Skills, Home Skills, Community Participation Skills, School Skills, Independent Living Skills, and Vocational Skills (Partington, J. W., 2012).

5. The PEAK: Relational Training System is a comprehensive approach to ABA Therapy, which embraces traditional verbal behavior accounts of basic language and incorporates contemporary behavior analytic strategies for promoting relational responding (a broad repertoire of learning meaning through relations between stimuli) which are responsible for our ability to understand and use abstract language. www.peak2aba.com
6. Accept Identify Move (AIM) raises the bar for what best practice can be for children struggling with social discomfort, challenging behaviors, and the daily struggles with life they must navigate. This text introduces and blends together the concepts of Mindfulness, Acceptance and Commitment Therapy, and Applied Behavior Analysis. Together the approach seeks to improve the lives of children with or without disabilities who struggle with social and emotional challenges. www.acceptidentifymove.com

Who will be involved in my child's session?

Spectrum of Hope involves one Board Certified Behavior Analyst and one ABA therapist in your child's session. Sometimes an Assistant Lead Supervisor may assist an RBT during a session.

Do you videotape my child?

We frequently take video recordings of therapy sessions. We review the videos and are happy to share the videos with you upon request. The primary use of these videos is for training, so that we can provide the best possible therapy for your child. Video is reviewed between our BCBA and the clinical team as a way to enhance supervision, collaboration, and treatment. A critical part of this training includes showing video segments of parents, ABA therapists, and children engaged in the program. These images illustrate developmental levels and therapeutic techniques and help demonstrate how to work with the broad array of children with ASD. With your consent we may also use in our social media platforms (Facebook, website).

Parent/Guardian Acknowledgement of Receipt

I have received a copy of the Parent Handbook and agree to the terms and conditions in the handbook.

Name _____ Signature _____

Date: _____