Dear Parent,

Thank you for selecting Family Beeginnings, INC. to meet the needs of your child. We appreciate your trust and look forward to getting to know you and your family better. If you have questions or concerns about anything, please do not hesitate to contact us.

We realize that getting a diagnosis of an Autism Spectrum Disorder (ASD) or a related disorder is a very stressful event for parents. Be assured, Applied Behavior Analysis (ABA) has been scientifically proven to work. Family Beeginnings will provide treatment to your child and also give support to you. You are your child's strongest advocate and there is much you can do to help your child to live a happy and independent life! Family Beeginnings strongly encourages parent involvement. We will train you to use the same ABA methods so that your child receives consistent, effective instruction. We also ask that you stay in constant contact with us. We want to know about every problem behavior so that we can help you eliminate it!

Family Beeginnings is determined to only use evidence-based practices. We cannot implement non-behavior-analytic interventions or non-evidence-based practices and cannot support practices that interfere with patient's programming or progress. Our treatment plans only include evidence based practices and are based upon the principles of Applied Behavior Analysis. We are committed to practicing within the scope of our professional practice and to following the ethical standards outlined by the Board Analyst Certification Board (BACB).

The first step to getting treatment is to email or fax us the following items:

1. **Completed admission forms, including signed consent forms**
2. **Original doctor's report when child was diagnosed**
3. **Recent Note from doctor saying that child is recommended to have ABA**
4. **Copy/Picture of your health insurance card (front and back)**
5. **Any previous ABA treatment records you may have (The more information we have about your child, the better we can serve you)**
6. **If your child is in school, please send us the IEP**

After completing the above steps, Family Beeginnings will then contact your insurance company and verify your benefits. Once approved, our experienced Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA) will set up an appointment for an initial behavior assessment with your child.

Initial assessments are done at our center and usually last about 2-4 hours. Our BCBA or BCaBA will use toys and games to identify your child's skill levels. Based on the data collected, the BCBA or BCaBA will create a detailed treatment plan for your child.

After 6 months of receiving ABA therapy, your child's skill levels will be evaluated again. The results will be compared to previous test's results to be sure that progress is being made. The BCBA or BCaBA will always discuss the results with you and make changes if needed. You will also be given access to your child's progress records on our secure online portal. Some children learn faster than others, so please be patient with them. We want every child to reach their fullest potential. When they succeed, we succeed!

Safety is our number one priority. In the event of a patient or employee injury that takes place in your home during a session, please complete the **Incident Report Form** included in this packet and turn it in via email to FamilyBeeginningsHR@beeABA.og

ABA should be a team approach. This team includes the child, caregivers, program supervisor, and behavior technician(s). It may also involve other stakeholders, or individuals who may support or benefit from the client's progress. Examples of stakeholders are: client's siblings, teachers, aides, etc. Below are commonly used terms to define roles within the client's ABA team:

Behavior Technician (BT): BTs are dedicated to providing one-on-one services to clients receiving ABA treatment. Behavior Technicians are responsible for implementing the treatment plans and protocols developed by Program Supervisors. Depending on a client's level of needs and frequency of services, your family may have more than one BT assigned to your case. A BT is a paraprofessional who practices under the close, ongoing supervision of a program supervisor. The BT is primarily responsible for the direct implementation of behavior analytic services.

Registered Behavior Technician (RBT): RBTs receive a internationally-recognized credential through the Behavior Analyst Certification Board (BACB). In order to apply for the credential, the applicant must: complete a 40-hour, intensive training on ABA; pass a competency assessment administered by a BCBA/BcaBA, and pass a certification exam. Once the credential is earned, the RBT practices under the close, ongoing supervision of a program supervisor. A RBT is a paraprofessional who practices under the close, ongoing supervision of a program supervisor The RBT is primarily responsible for the direct implementation of behavior analytic services. Further information regarding certifications can be found at https://bacb.com.

Program Supervisor/ Board Certified Behavior Analyst or Assistant Behavior Analyst (BCBA/BCaBA): All program supervisors are board certified BCBA or BCaBA and licensed through the *Virginia Board of Medicine*as behavior analyst (LBA/LABA). The program supervisor is responsible for coordinating services, conducting assessments, treatment plan development, and supervising Behavior Technicians (BT) and Registered Behavior Technicians (RBT). A program supervisor may also conduct one-on-one sessions. Your program supervisor will be the main contact person throughout the client's therapy. The BCBA/BCaBA certifications are delivered through the Behavior Analyst Certification Board (BACB). A BCBA/BCaBA is a therapist with an expertise in the field of behavior analysis. All BCBAs are required to possess a Master's Degree while BCaBA's are required to possess at least a Bachelor's Degree and a Graduate Certificate. A BCBA/BCaBA receives specialized training, including coursework and practical experience, in behavior analysis. The program supervisor works closely with the family, administers assessments, develops intervention plans, and supervises the behavior technician.

Family Beeginnings
Behavior ABA

ADMISSIONS FORM

Today's Date:			
Child's Name:			❑male ❑female
Child's Date of Birth:			
Custodial Parent: (Circle one)	Both: Parents are married	Child lives with Dad	Child lives with Mom

Custodial Parent's Name:	
Custodial Parent's Email:	
Custodial Parent's Phone:	
Custodial Parent's Address:	
Parent #2 Name:	
Parent #2 Email:	
Parent #2 Phone:	
Sibling Name(s):	
Emergency Contact (other than parents):	

Insurance Company:	(send us a copy of the front an back of your insurance card)
Member ID:	
Group#	
Policyholder's Name: (Usually a parent)	
Policyholder's Date of Birth:	

Interested in: (Circle an option)				
Center	**Center**	**Center**	**In-Home**	**In-Home**
9:30am-3:30pm	9:30am-3:30pm	4pm-7pm	7am-3pm	3pm-7pm
Full-Time(Mon-Fri)	Part-time (<5 days/wk)		(Minimum of 2 hrs required per session)	

Describe the age and symptoms that were first noticed:	
*Date of Diagnosis:	(Please send us the full doctor's report of this visit- must include the testing scores and How many hours/week of ABA the doc recommends)
*Diagnosing Doctor:	
Child's Primary Diagnosis: Secondary Diagnosis, if any:	1) **Autism Spectrum Disorder** 2)

List Child's Current Medications and Doses:	
List any allergies Or food restrictions:	
Has your Child ever received ABA before? If yes, where? What year did they start?	(Please send us the old records)
Is your child currently in Speech Therapy?	If so, where and how many days per week?
Is your child currently in Occupational Therapy?	If so, where and how many days per week?
Does your child attend school? Name of school: If so, are they in a special needs class?	(Please send us the IEP)

Family Beeginnings
Beehavior ABA

Acknowledgement of Receipt of Notice of Privacy Practices

Family Beeginnings, INC. is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). Below is our privacy policy:

1. Family Beeginnings will not use or disclose your PHI for marketing or fundraising purposes; Family Beeginnings will not sell your PHI to anyone for any reason.
2. Family Beeginnings will only use your PHI in an appropriate manner for treatment.
3. Family Beeginnings will only disclose PHI to the child's legal guardian. A legal guardian must give written authorization to allow us to share PHI with others.
4. Family Beeginnings may disclose your PHI without your written permission when required By Law. When disclosure is (a) required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement; (b) compelled by a party to a proceeding before a court, arbitration panel or an administrative agency pursuant to its lawful authority; (c) required by a search warrant lawfully issued to a governmental law enforcement agency; or (d) compelled by the patient or the patient's representative pursuant to state or federal statutes or regulations, such as the Privacy Rule that requires this Notice.
5. Family Beeginnings may disclose your PHI without your written permission for health oversight activities authorized by law including, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
6. Family Beeginnings may disclose your PHI without your written permission to avoid harm. When disclosure: (a) to law enforcement personnel or persons may be able to prevent or mitigate a serious threat to the health or safety of a person or the public; (b) is compelled or permitted by the fact that the Client is in such mental or emotional condition as to be dangerous to him or herself or the person or property of others, and if AST determines that disclosure is necessary to prevent the threatened danger; (c) is mandated by state child abuse and neglect reporting laws (for example, if we have a reasonable suspicion of child abuse or neglect); (d) is mandated by state elder/dependent abuse reporting law (for example, if we have a reasonable suspicion of elder abuse or dependent adult abuse); and (e) if disclosure is compelled or permitted by the fact that you or your child tells us of a serious/imminent threat of physical violence against a reasonably identifiable victim or victims.
7. Family Beeginnings may disclose your PHI without your written permission to company attorneys, accountants, consultants, and others to make sure that Family Beeginnings is in compliance with applicable laws.
8. Family Beeginnings may disclose your PHI without your written permission to your health insurance company to obtain benefit information, payment for treatment and services provided.
9. Family Beeginnings may disclose your PHI without your written permission in the event of an emergency situation (such as a hospital visit).
10. Family Beeginnings employees are not allowed to communicate by text message. The only HIPAA compliant methods of contact are phone calls, encrypted messaging, or person-to-person.
11. You have the right to access your PHI at anytime. Family Beeginnings does not charge fees to access your records.
12. You have the right to know who had access to your PHI within the last 6 years.
13. You have the right to limit our access to your health records.
14. You have the right to revoke access to your PHI that was previously given to us at any time.
15. Family Beeginnings will notify you immediately if we become aware that an unauthorized person accessed your PHI.
16. You have the right to complain to the US Department of Health and Human Services if you feel that your rights have been violated.

_____
initials

Family Beeginnings policy does not allow parents to take pictures/videos/audio of any clients during therapy hours.

_____
initials

When clients/parents/visitors come into the center (or observe therapy outside of the center), it is possible that they see other clients or overhear their ongoing treatment. By signing this agreement, you agree to keep confidential all information obtained by your presence concerning other clients.

We are required by law to maintain the confidentiality of health information that identifies clients. We also are required by law to provide this notice of our legal duties and the privacy practices that we maintain in our practice concerning our client's PHI. I have read and understood Family Beeginnings, INC.'s Privacy Policy. I have been given a copy of Family Beeginnings's *Notice of Privacy Practices ("Notice"*), which describes how my Health Information is used and shared. I understand that Family Beeginnings has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Company Director's Email.

_____ _____

signature Date

Family Beeginnings
Beehavior ABA

PAYMENT AGREEMENT

Print Child's Name	
Print Parent's Name	

AUTHORIZATION:

- I authorize Precision ABA Group Of Virginia, INC. also known as Family Beeginnings, INC. to make medical reimbursement claims with my health insurance policy for services provided to my child.
- Any pre-authorization obtained by Family Beeginnings, iNC. is not a guarantee of payment by my insurance.
- I understand and accept that I am ultimately financially responsible for all amounts not covered by my health insurance, including (but not limited to) co-payments, deductible, co-insurance, and other fees (excluding Medicaid clients).
- Discounts for copays and deductible amounts are not allowed by law.
- I understand and agree that I am responsible for the payment of all charges incurred regardless of any insurance coverage or other plans available to me.
- I understand that Family Beeginnings, INC. will bill me monthly for balances left unpaid by my health insurance. Invoices must be paid within 15 days of the date on the invoice.
- If any of my invoices remain unpaid for over 90 days, my child's services may be terminated.

ADDITIONAL FEES:

- Annual registration fee (non-refundable; excludes Medicaid clients)
- Late fee for every 15 days that invoice payments are late
- Fee for each returned check (such as NSF)
- **A 14 day written notice is required to make a schedule change**
- $50 no call/no show fee for unannounced cancellations
- $25 late pick-up/drop-off fee at 15 minutes after the scheduled session was to begin or and after the 16th minute an additional 1$ fee is applied for every additional minute.
- $1 per diaper if I do not supply my own to the center
- Replacement fees for Family Beeginnings electronics when damaged by your child
- Processing fees for payments made online
- Any and all collections costs and/or attorney's fees if any delinquent balance is placed with an agency or attorney for collection, suit, or legal action.

INVOICE DISPUTES:

- If I believe there is an error on my invoice, I must contact the Director Of Operations at **ismacoleman@beeABA.org**, within 90 days of receipt of the relevant invoice in order to allow review and consideration.
- Inquiries/Disputes regarding invoices over 90 days old will be deemed untimely and payment will not be refunded.

Parent's Signature	
Parent's SSN	
Parent's DOB	
Date	

INFORMED CONSENT FOR SERVICES

Print Child's Name	
Print Parent's Name	

I hereby voluntarily apply for and consent to behavioral services by the staff of Family Beeginnings, INC. This consent applies to myself and the child named above.

I understand that parental involvement and training are required. I understand that Family Beeginnings encourages both parents to attend the required meetings.

I understand that my child's attendance is essential to the program and must be maintained at a level of 85% of scheduled sessions each month, and over the duration of enrollment.

I understand that I may ask for a referral to another professional if I am not satisfied with the progress of my treatment.

I understand that I have the right to refuse services at any time. I understand and agree that my continued participation implies voluntary informed consent. I also understand that Family Beeginnings has the right to refuse services at any time.

Parent Signature	
Date	

Family Beeginnings
Behavior ABA

INFORMED CONSENT FOR TELEHEALTH SERVICES

Print Child's Name	
Print Parent's Name	

Health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth,", this means that I may be evaluated and treated by a health care provider or specialist from a different location.

Since this is different than the type of consultation with which I am familiar, I understand and agree to the following:

1. The consulting health care provider or specialist will be at a different location from me.
2. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present.
3. Video recordings may be taken of the telehealth consultation. Video recordings and other data, including documents, images, and photos may be kept, viewed, and used for purposes including teaching, training, technical, scientific, research, or administrative purposes.
4. The health care provider will keep a record of the consultation in my medical record.

Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data. I further understand that I have the right to:

1. Refuse the telehealth consultation, or stop participation in the telehealth consultation at any time.
2. Limit any physical examination proposed during the telehealth consultation.
3. Request that the presenting practitioner/provider refrain from transmitting my information if I make the request before the information is transmitted.
4. Request that nonmedical personnel leave the room(s) at any time.
5. Request that all personnel leave the room(s) to allow a private consultation with the off-site specialist(s).

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Custodial Parent's Signature:	
Date:	

RELEASE OF LIABILITY

Print Child's Name:	
Parent's Name:	

In-Center Therapy:

Occasionally, Clients may bring personally owned devices (such as communication boards, iPads/tablets, iPods, specialized games, etc.) into the center. I understand that Family Beeginnings, INC. is not responsible for any damage/loss/theft to my property.

I understand that my child is never allowed to play with a Family Beeginnings owned iPad/tablet/electronics. I accept financial responsibility / liability for any damage done to Family Beeginnings electronics by my child.

In-Home Therapy:

Family Beeginnings requires a parent/caregiver to be present during all in-home therapy at all times. Family Beeginnings employees strive to avoid inappropriate situations. I understand that, if my child is not toilet-trained, I am responsible for changing diapers/wiping/bathing my child.

I understand that I am personally responsible for cleaning messes made by my child during therapy sessions.

I understand that Family Beeginnings employees may bring electronics, toys, books, or other equipment into my home for use during therapy sessions. I understand that my child is not allowed to play with Family Beeginnings owned property when sessions are not occurring. I understand that my child is never allowed to play with Family Beeginnings owned tablets/electronics. I accept financial responsibility/liability for any damage done to Family Beeginnings property by my child.

I hereby release Family Beeginnings, INC. from any liability/claims/demands related to any loss/damage/injury to any of my personally owned property that my child may cause during therapy sessions.

I understand that I am financially responsible for damage caused by my child to Family Beeginnings property or a Family Beeginnings employee's property. I understand that Family Beeginnings is not responsible for any damage done by my child to my property.

Custodial Parent's Signature:	
Date:	

Family Beeginnings
Beehavior ABA

Parent Handbook Agreement

Print Child's Name:	
Parent's Name:	

IN-CENTER THERAPY SESSIONS

BEFORE YOUR SESSION

- Children should be dressed and fed prior to drop off at our center (unless these skills are being addressed in the program).
- FAMILY BEEGINNINGS is not liable for children outside of the checked-in hours. Parents are responsible for children in the parking lot or anywhere outside of the FAMILY BEEGINNINGS center.
- Due to safety reasons, FAMILY BEEGINNINGS does not provide any meals or snacks for the children. All students are expected to pack a lunch and reusable water bottle. Our center is a peanut free facility. Parents are responsible for notifying the facility, in writing, of any allergies or other medical conditions upon enrollment or as the parents become aware of them.
- Clients enrolled in FAMILY BEEGINNINGS are not required to be toilet-trained, but parents are required to send in the appropriate diapering and/or toileting supplies that their child may need in their backpack. This includes diapers, wipes, creams, changes of clothing, and gloves to allow our staff a minimum of 3 changes per day.
- Parents are responsible for supplying the child's medications, and must complete the medical administration form.
- Children do not learn when they are unhappy, bored or stressed. It is our job to motivate your child to learn! Let us know what rewards your child is likely to enjoy. We request parents provide an assortment of their child's favorite items.
- **If a client arrives after 15 mins from their scheduled time, they will be charged a $25 late fee. Tardiness exceeding 60 minutes, will result in a $50 cancelation fee and cancelation of session.**
- Attendance must be maintained at a level of 85% of scheduled sessions each month, and over the duration of enrollment. Extended vacations are not allowed, as it disrupts the progress of therapy.

DURING YOUR SESSION

- Parents must complete the sign-in form at the beginning of each session. Parents are responsible for ensuring accuracy of hours.
- Therapists may use the first and last 15 minutes of the session for set-up and clean up.
- Occasionally, clients may bring personally owned devices (such as communication boards, iPads, iPods, specialized games, etc.) into the center. Before any client-owned equipment/devices are brought on-site, a release of liability form must be completed by the parent. Parents are financially responsible for damage caused by your child to FAMILY BEEGINNINGS property or a FAMILY BEEGINNINGS employee's property. FAMILY BEEGINNINGS is not responsible for any damage done by your child to your property
- You are welcome to view your child's session on our video security system from our Viewing Room. All non-client minors in our center (such as siblings) must be accompanied by an adult at all times.

AFTER YOUR SESSION

- Parents must complete the sign-out form at the end of each session.
- FAMILY BEEGINNINGS will charge a $25 late pick-up fee for each 15 minutes after your scheduled session has ended.
- Prior to someone other than a parent picking up a child from our center, parents must fill out a form to authorize them to do so. FAMILY BEEGINNINGS reserves the right to ask for their ID.
- Parents will receive a Daily Report about the progress made within the session.
- FAMILY BEEGINNINGS requires parents to participate in Caregiver Training. Parents will be given "homework assignments" and will be frequently contacted about these assignments.

IN-HOME THERAPY SESSIONS

BEFORE YOUR SESSION

- Children should be dressed and fed prior to the session (unless these skills are being addressed in the program).
- Prepare an area in your home to be used for therapy. It must be a comfortable temperature, well lit, and relatively free of distractions.
- Children do not learn when they are unhappy, bored or stressed. It is our job to motivate your child to learn! Let us know what rewards your child is likely to enjoy. We request parents provide an assortment of their child's favorite items.
- A parent or responsible adult must be present in the home at all times during therapy sessions. FAMILY BEEGINNINGS employees are not allowed to change diapers, undress, or bathe a child. If needed, parents will also be the one to administer any first aid to your child.
- **If a therapist arrives at your home and you are not present, they will wait 15 mins before leaving. You will be charged a $25 no show fee and applicable mileage fees.**
- Attendance must be maintained at a level of 85% of scheduled sessions each month, and over the duration of enrollment. Extended vacations are not allowed, as it disrupts the progress of therapy.

DURING YOUR SESSION

- Therapists may use the first and last 15 minutes of the session for set-up and clean up
- FAMILY BEEGINNINGS's therapists are not obligated to work with siblings. If a therapist feels a sibling can be used as a participant in a session, it is at their discretion.
- Parents are financially responsible for damage caused by your child to FAMILY BEEGINNINGS property or a FAMILY BEEGINNINGS employee's property. FAMILY BEEGINNINGS is not responsible for any damage done by your child to your property.
- If your child needs to be transported, it will be the responsibility of the parent or guardian to do this. FAMILY BEEGINNINGS employees are **not** allowed to take a child in their automobile at any time.

AFTER YOUR SESSION

- Parents must complete the sign-out form at the end of each session.
- Do not allow your child to play with FAMILY BEEGINNINGS therapy materials and reinforcers outside of therapy time.
- FAMILY BEEGINNINGS requires parents to participate in Caregiver Training. Parents will be given "homework assignments" and will be frequently contacted about these assignments.

Parent Signature:	
Date:	

Family Beeginnings
Beehavior ABA

Permission to Photograph

Clients name_____ DOB: _____

- ❏ I give permission and consent for Family Beeginnings, INC. to photograph my child and/or myself during the time my child is enrolled in services. I understand these photographs may be used in educational training presentations and shared through our HIPAA secure portal, TheraWe.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date

Permission to Videotape or Audiotape

- ❏ I give permission and consent for Family Beeginnings, INC. to videotape and/or audio tape my child and/or myself during the time my child is enrolled in services. I understand these tapes will not be used outside the company and will be kept confidential. I understand that the recordings will be used for the purposes of sharing progress through our HIPAA secure portal, TheraWe, and for developing more effective educational and therapeutic plans for my child and also for the purpose of education and training for Family Beeginnings, INC.

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____
Date

Family Beeginnings
Beehavior ABA

Sick Child Policy

Our therapists tend to become ill when their clients are ill, which causes canceled sessions and decreased availability of therapy hours for your child, as well as the children of others.

Please reschedule therapy sessions if your child has a fever of 100 degrees or above, is vomiting, has diarrhea, any type of skin rash, abnormal bumps or blisters, or any contagious illness (including mucus that is green or yellow in color) at least 24 hours prior to the scheduled session. If your child is too sick to go outside or to school, then he or she is too sick to receive Family Beeginnings, INC. services.

If your child requires prescription medication for a sudden illness, we ask that you not schedule therapy sessions until they have been on the medication for at least 48 hours or until they are no longer contagious.

Prior to beginning a session, if your child appears ill, our therapists may ask you to take your child's temperature. Please keep a thermometer on hand so that you may take your child's temperature upon request.

To ensure effective treatment and to protect the health of Family Beeginnings, INC.'s therapists, sessions may be cancelled and rescheduled at Family Beeginnings, INC. discretion if Family Beeginnings, INC. becomes concerned about the health of your child and/or Family Beeginnings, INC.'s therapist.

The nature of our program dictates consistent expectations of a child's performance and this can be difficult if a child is not feeling well. We appreciate your good judgment and understanding in these matters.

I, _____ the parent/legal guardian of the above named child, hereby understand agree to adhere to Family Beeginnings, INC. sick policy.

_____ _____

Signature of Parent/Guardian Date

COVID-19

Dear Parents and Guardians,

Out of an abundance of caution, Family Beeginnings, INC. is implementing an action plan to address evolving circumstances involving the spread of the coronavirus (COVID-19). We believe this action plan aligns with our commitment to ensure the health and safety of our staff, clients and their families. Family Beeginnings, INC. administration will communicate any updates to this plan as well as concerns about the spread of the virus to staff and clients on an ongoing basis.

Preventative Actions

Family Beeginnings, INC., has implemented a mandatory temperature check and screening prior to each session. Our team is actively cleaning and sanitizing high touch places such as doorknobs, tables, faucets, iPads, and children's toys frequently throughout the day. Materials in sensory spaces such as body socks and swings will be washed several times a week. We will keep our ball pit open for now and clean them daily. If there are increased incidents in our community, these spaces will be temporarily off-limits. *Furthermore, non-authorized personnel, including parents or caregivers will be prohibited to enter our facility until further notice*

Hand Washing instructions will be posted in all bathrooms to promote staff handwashing. Clients will be encouraged to wash their hands upon arrival, before eating, before leaving for the day and after sneezing or coughing in them. Clients who have sensory challenges with handwashing will have modified hand washing routines which are individualized to them. If you have concerns about specific products used for handwashing, please reach out to the clinical director.

Each client's learning areas will be supplied with hand sanitizer. In addition, their tables and learning materials will be wiped down before and after each session with antibacterial wipes. If your child has an allergy or sensitivity to antibacterial gel or cleaning products, please provide a written notice to FamilyBeeginningsHR@beeABA.org. For our little learners who like to mouth items, bins will be placed around the clinic for any item that has come in contact with their mouth, to ensure that it is sanitized before another child is able to access it.

Community spaces such as kitchens, meeting rooms and work rooms will be cleaned and wiped down after each use. To ensure they are clean and disinfected, all kitchen and eating utensils will be washed in the hottest possible water.

As fundamental as this information is, it bears repeating that to help prevent the spread of respiratory viruses, staff and clients should remember to:

- Cover your cough or sneeze
- Wash your hands frequently with soap and water for at least 20 seconds
- Use alcohol-based hand sanitizer
- Avoid touching your eyes, nose and mouth with unwashed hands
- See your doctor if you have a fever, cough, running nose, congestion, vomiting, diarrhea, body aches and fatigue
- Stay home and limit contact with others if you are sick

We urge families to keep their children home and cancel sessions if your child is sick. Please note that Family Beeginnings, INC. has the right to deny services or end services early should a client or family member present the following symptoms:

Notification of Travel

We are asking that families and team members notify our HR team if you have travel overseas or domestically outside of *Virginia, Maryland or Washington D.C*. in the last 30 days or if you have plans to travel. In addition, clients or staff who have family members who reside with them who have traveled to or had stopovers in countries that are considered Level 3 by the Centers for Disease Control and Prevention or higher, should self-quarantine for 14 days.

Information for travelers can be found on the CDC website:

https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

Closings

Family Beeginnings, INC. will remain vigilant in staying up to date with all local and national recommendations regarding business closures. Family Beeginnings, INC. intends to stay open, even if schools close, unless local officials advise otherwise. In the event that a client or staff member contracts COVID-19, all parents and staff members will be contacted immediately, and the clinic will close for a ***minimum*** of 1 day to ensure that the space can be professionally cleaned and disinfected. Any client or staff member who reports a diagnosis of COVID-19 will be suspended for a minimum of 14 days or until notice that there is no risk of contracting the virus is provided by a medical official.

We understand this is a stressful time for our families and want to ensure you that your child's health is our first priority. We will continue to keep you informed of any updates.

We are agreeing to continue to provide services in the clinic setting and home setting, however this agreement does not guarantee services and does not override any orders that may come from the CDC, Governor, or other governing body. This agreement and the terms of this agreement may change at any time as this situation continues to evolve. In the event that we are no longer able to provide in person services, we will follow our tele-health policies and procedures.

By signing this agreement, you are acknowledging that you have read and understand the expectations for your child to continue receiving services from Family Beeginnings, INC. You acknowledge that you are signing of your own free will. By signing this agreement, you also acknowledge that there is inherent risk in continuing to receive services either in a clinic setting or face-to-face in home while COVID-19 is still actively spreading. Even with all the precautions we are putting into place, we cannot guarantee that there will not be a transmission of COVID-19 between your household and our staff. By signing this agreement, you acknowledge that you will hold harmless Family Beeginnings, INC., and all associated personnel for all aforementioned companies, for any and all harm that may come from continuing services during the COVID-19 pandemic.

Client Name: _____

Parent/Guardian Name: _____

Date: _____

Collaboration & Coordination of Care With Other Service Professionals

In order to provide your family the most comprehensive care and help improve patient outcomes, Family Beeginnings focuses on a multidisciplinary team approach. Our goal is to harbor effective communication and coordination of care with all of your child's service care providers. With your permission, your program supervisor will make reasonable efforts to collaborate with other professionals on your child's treatment team such as occupational therapists, school employees, speech-language pathologists, and/or physicians to maximize your child's progress.

Name of School: _____ Teacher: _____
Contact Number of Teacher: _____ Email: _____

I give permission for Family Beeginnings and its affiliates and/or employees to coordinate and release my child's medical records to his or her school: Yes/No

Name of speech-language pathologists (SLP): _____
Contact Number of SLP: _____ Email: _____

I give permission for Family Beeginnings and its affiliates and/or employees to coordinate and release my child's medical records to his or her SLP: Yes/No

Name of Occupational Therapist (OT): _____
Contact Number of OT: _____ Email: _____

I give permission for Family Beeginnings and its affiliates and/or employees to coordinate and release my child's medical records to his or her OT: Yes/No

Name of Physician: _____
Contact Number: _____ Email: _____

I give permission for Family Beeginnings and its affiliates and/or employees to coordinate and release my child's medical records to his or her physician: Yes/No

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Date: _____

Family Beeginnings
Behavior ABA

Client Availability

Client:_____ DOB: _____ Period: Fall Summer

TIME/DAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8:00- 8:30							
8:30- 9:00							
9:00- 9:30							
9:30- 10:00							
10:00- 10:30							
10:30- 11:00							
11:00- 11:30							
11:30- 12:00							
12:00- 12:30							
12:30- 1:00							
1:00- 1:30							
1:30- 2:00							
2:00- 2:30							
2:30- 3:00							
3:00- 3:30							
3:30- 4:00							
4:00- 4:30							
4:30- 5:00							
5:00- 5:30							
5:30- 6:00							
6:00- 6:30							
6:30- 7:00							

On the table below, please cross out (X) the times that you ARE available for ABA services

All sessions will be center based unless otherwise recommended. Weekend sessions are not guaranteed - please do your best to open availability M - F as much as possible.

I understand that Family Beeginnings will try its best to accommodate my schedule. However, due to therapist's' and/or my own availability, I may not always have the hours requested.

Legal Guardian Signature: _____ Date:_____

Home Safety Checklist

Client Name:_____ Client DOB:_____

Must be completed by the case supervisor (BCBA/BCaBA) prior to first session with BT/RBT

Yes	No	Questions	Comments/Concerns & Recommendations
		General Employee Safety	
		In what type of residence does the client reside in? ○ Single-family home ○ Townhome ○ Apartment/Condominium ○ Other _____	
		Need a parking pass?	
		○ Reserved parking? ○ Driveway parking? ○ Street parking?	
		Who lives in the home? (include relationship and age)	
		Any pets? Number of pets? What type?	Number:____ Type:_____
		Firearms in the home?	
		Other weapons? If yes, explain.	
		Smoke detectors?	
		Fire extinguisher?	
		Working A/C unit?	
		Working heat?	
		Access to a bathroom?	
		Designated workspace? Explain.	
		Any hazards in the environment? Explain.	
		Overall housekeeping? Please explain.	

Is it safe for a Family Beeginning's staff member to work in client _____ home setting: Yes / No

Supervisor Signature: _____ Date Completed:_____

Family Beeginnings
Behavior ABA

Incident Reporting Form

Instructions: Fill out this form after any incident in which medical treatment, not limited to but including: bruises, cuts, scrapes or falls, or the use of Safety-Care physical skills were required. This form should be completed by the Family Beeginnings staff responsible for the client involved in the incident. After completion the form should be signed by staff, caregiver and supervisor.

Reporter Information	Name and title (BT/ RBT):
Describe the incident (Include time, location and all involved. Use initials for clients)	Time: _____ Location: _____ Person's Involved: _____

Were the caregivers notified? (Circle one) Yes No	
__ Phone Call ___ In Person __ Written Notification	Time:

Who was injured (check all the apply)	
___ Injury to client Initials: _____	____ Injury to peer Initials: _____
___ Injury to staff Initials: _____	

Describe injury and medical care given.

Were any physical restraints used? (Circle one) Yes No
If yes describe restraint and length:

Describe the incident (Use ABC data)		
Antecedent	Behavior	Consequence