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.

When you receive treatment or benefits from Andrews Center, we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care, or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency.

We may use and disclose your health information without your authorization to contact you for the following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following purposes:

- For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;
- To comply with workers compensation laws and similar programs;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency reasonably believes you are a victim of
- abuse, neglect, or domestic violence we will make every effort to obtain your permission, however, in some cases we may be required or
- authorized to alert the authorities;
- For health oversight activities such as audits, investigations, and inspections of DSHS facilities;
- For research approved by an Institutional Review Board or privacy board; for preparing for research such as writing a research proposal; or for research on decedents information;

- To create or share de-identified or partially de-identified health information (limited data sets);
- For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
- For law enforcement purposes such as identifying or locating a suspect or missing person;
- To coroners, medical examiners, or funeral directors as needed for their jobs;
- To organizations that handle organ, eye or tissue donation, procurement, or transplantation;
- To avert a serious threat to health or public safety;
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and
- As otherwise required or permitted by local, state, or federal law.

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized by law. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may cancel your authorization by writing to the privacy officer per below.

Acknowledgement

By signing below, I am acknowledging that I have received the Notice of Privacy Practices and understand I am able to request this consent and ask questions about these documents at any time.

I understand this consent shall remain effective only so long as is necessary to fulfill its purpose.

My consent is freely given, and I understand that it may be withdrawn at any time apart from any action that has already been taken.

____ ________________________

Client or Parent/Guardian Signature (if a minor) Date

Consumer's Name: ________________________

Application for Services

Andrews Center: Treatment and Learning Center
1722 West Front St.
Tyler, Texas 75702
Phone: 903 593-4004 Fax: 903-593-4121 Email: TLCABA@andrewscenter.com

Thank you for your interest in the Andrews Center Autism Programs. At the Treatment and Learning Center (TLC), we are dedicated to piecing together our East Texas Community by providing quality Applied Behavior Analysis (ABA) tailored to meet the needs of each child and teach them how to better communicate and interact with their environment, family, friends, and teachers.

TLC's Programs

- The Focus program is a treatment model that provides short-term 1:1 ABA treatment for 6 hours a week for 6 months with some parent training and is usually funded through a grant from the Texas Health and Human Services Commission (formerly DARS) with a cost share.
- The Comprehensive program is a treatment model that provides 1:1 intensive ABA treatment 20-40 hours per week and is funded through insurance and private pay.

Please select the funding source:

○ Focus Program (6 hours per week, short time, focused treatment model)

○ Comprehensive Program (20-40 hours to the week, long term, comprehensive treatment model)

My priority of treatment:

○ Reduction of Interfering Behaviors

○ Increasing functional language and communication skills

○ Social skills training

○ Other: ____

How did you hear about us?

○ Referred by: ____

○ Other:____

Consumer's Name: ___________________________

ALL THE INFORMATION IN APPLICATION IS REQUIRED FOR SERVICES

Today's Date ________/______/_______

IDENTIFYING INFORMATION:

Child's Full Name:		Date of Birth:		Age in Years:	
Social Security Number:		Child's Gender:		Language Spoken in Home:	
Height: *ft.* *in.*		Weight: *lbs.*		Race/Ethnicity:	
Address:		City:	State:	Zip Code:	County:

DIAGNOSIS INFORMATION

Diagnosis/Diagnoses:	Doctor who provided diagnosis:
Age at Diagnosis:	Year diagnosis was given:

FAMILY INFORMATION

Parent/Guardian Name:	Relationship to child:
Address (if different from child):	City, State, Zip:
Phone Numbers Cell/Home: Other:	Email Address:
Additional Parent/Guardian Information	
Parent/Guardian Name:	Relationship to Child:
Address (if different from child):	City, State, Zip:
Phone Numbers Cell/Home: Other:	Email Address:
Family Size:	Gross Annual Income for Family:

Consumer's Name: ___________________________

FUNDING INFORMATION

Does your child have CHIP? **Yes** **No**	CHIP Number:
Does your child have Medicaid? **Yes** **No**	Medicaid Number:
Does your child have Medicare? **Yes** **No**	Medicare Number:

Does your child have private insurance? **Yes** **No**	Insurance Company:
Insurance Phone Number:	Insurance Address:
Policy Holder Name and DOB:	Relationship to Consumer:
Policy Number:	Group Number:

Please attach required documentation:

- ○ Autism Diagnosis Report (must be medical doctor or PsyD)
- ○ Copy of insurance card
- ○ Proof of Texas Residency (i.e., Texas Driver's License, electric bill, etc.)
- ○ Proof of Income (tax return or 3 pay stubs)
- ○ HHSC Form 6000
- ○ HHSC Cost Share Attestation
- ○ Custody Agreements (if applicable)
- ○ Individualized Education Plan (if applicable)

Consumer's Name: _________________________

Please initial:

______ I would like to be contacted by a current or former TLC parent regarding their experiences and what to expect.

______ I would like to be added to the TLC email list for information regarding events, trainings, etc.

*Feel free to visit our Facebook page at https://www.facebook.com/treatmentandlearningcenter/
or our website at tlcaba.org*

Printed Name of Parent/Guardian: ____

Signature of Parent/Guardian: ____ Date:______________________

Form 6000
April 2017

Children's Autism Program Enrollment

If multiple children in the household are being enrolled in the Children's Autism Program, use a separate enrollment form for each child.

Family Information

Child's first name:	Middle name:	Last name:	Birth date:

Parent's or guardian's name: Relationship to child:	Telephone: ( ) Email:	Child's sex: ☐ Female ☐ Male	
Address:	City:	State: TX	ZIP code:

Diagnosis:	Age at diagnosis:	Language spoken:	Race and/or ethnicity:
Proof of Texas residency:		County:	Family size:

Income Information

Select all that apply:

☐ Gross income	Amount: $
☐ Allowable deductions	Amount: $
☐ Adjusted gross income	Amount: $

Insurance Information

Do you have CHIP?	☐ Yes ☐ No	CHIP Number:
Do you have Medicaid?	☐ Yes ☐ No	Medicaid Number:
Do you have Medicare?	☐ Yes ☐ No	Medicare Number:
Do you have insurance?	☐ Yes (If yes, complete insurance information below.)	☐ No

Insurance carrier's name:	Policy holder's name:
Referral source:	Previous ECI services: ☐ Yes ☐ No

Signature

I certify that the statements made for the Children's Autism Program Enrollment application are true and correct to the best of my knowledge.

Parent's, guardian's, or caretaker's signature: X	Date of signature:

For Office Use Only

Case ID number:	Enrollment date:

DARS6000 Instructions

Use

DARS6000 collects the required demographic and financial information to determine a family's ability to contribute to a child's autism services and how the DARS Autism Program Sliding Scale Fee Schedule is applied. **Note:** All fields must be completed.

Copies and Distribution

The original signed DARS6000 is to be retained in the child's record and the information entered into the DARS Autism Database by the 10th calendar day of the month following enrollment. The record must be retained for three years following the close of the contract or for the duration of the contractor's retention period, whichever is longer.

Instructions

Family Information

Child's name—name of child being enrolled into the DARS Autism Program

Date of birth—date of birth of child being enrolled into the DARS Autism Program

Case ID number—unique ID number assigned by the DARS Autism Provider

Parent or guardian name—name of the parent or guardian of the enrolled child

Relationship—of the parent or guardian of the enrolled child

Telephone—phone number that is best to reach the parent or guardian

Email—email address of the parent or guardian of the enrolled child

Gender—of the enrolled child

Address, city, state, and ZIP code—of the family home

Diagnosis—documented diagnosis of autism spectrum disorder

Age at diagnosis—age of the enrolled child when the documented diagnosis of autism was made

Language spoken—primary language spoken at home by the family and the enrolled child

Race and/or ethnicity of the enrolled child—enter as many categories as apply

- White
- Black or African American
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or other Pacific Islander
- Hispanic or Latino

Proof of Texas residency of the family of the enrolled child—proof can be an income tax form, driver's license, or utility bill with the current Texas address of the family

County—the county of residence of the family of the enrolled child

Family size—equals the sum of the number of

- parents or guardians, plus all minor siblings who reside in the home of the enrolled child; and
- other dependents, such as a child age 19 or older, parent, stepparent, grandparent, brother, sister, stepbrother, stepsister, or in-law whose gross income is less than $3,900 a year and for whom more than half of the person's support is provided for by the parent(s) or guardian(s) during the calendar year

Income Information

Annual gross income—enter the gross income in this field if the family chooses to use Options 2 or 3 as explained in the adjusted gross income section below

Annual allowable deductions—expenses that are not reimbursed by other sources; allowable deductions are limited to

(A) the actual medical or dental expenses of the parent or dependent that are primarily related to alleviating or preventing a physical or mental defect or illness, were paid over the previous 12 months, are expected to continue during the eligibility period, and are limited to the cost of

(i) diagnosis, cure, alleviation, treatment, or prevention of disease;

(ii) treatment of any affected body part or function;

(iii) legal medical services delivered by physicians, surgeons, dentists, and other medical practitioners;

(iv) medication, medical supplies, and diagnostic devices;

(v) premiums paid for insurance that covers the expenses of medical or dental care;

(vi) transportation to receive medical or dental care; and

(vii) medical or dental debt that is being paid on an established payment plan;

(B) child-care and respite expenses for a family member;

(C) costs and fees associated with the adoption of a dependent child; and

(D) court-ordered child support payments paid for a child who is not counted as a family member or dependent

Adjusted gross income (AGI)—the family has three options to determine the AGI amount:

The family may use the AGI from the previous year's filed federal tax return, found on Internal Revenue Service (IRS) Form 1040, line 37.
The family may use the gross income from the previous year's filed federal tax return minus allowable deductions. See below for the allowable deductions. The family must provide documentation of the allowable deductions.
If the family did not file a federal tax return in the previous year, the family must provide proof of annual income and the allowable deductions. The gross income includes all income classified as taxable income by the IRS before federal allowable deductions are applied.

The provider calculates the AGI by subtracting the allowable deductions from the gross income.

Families with no income must sign a statement indicating they have no income. You must contact DARS before the enrollment of a child in all cases where AGI cannot be determined.

Insurance Information

Children's Health Insurance Program (CHIP), Medicare, Medicaid, and other insurance—select all that apply for the enrolled child; if the child has CHIP, Medicare, or Medicaid, the ID number must be entered and a copy of the card retained in the child's record

Insurance carrier name—the name of the private insurance carrier with which child has benefits or coverage

Policy holder name—the name of the policy holder on private insurance

Referral source—the person or entity that referred the enrolled child to the DARS Autism Program

Prior Early Childhood Intervention (ECI) services—ECI services the child has had before enrollment in the DARS Autism Program

Signature—of the parent or guardian of the enrolled child

Enrollment date—the date services begin or the date of the pre-testing of the enrolled child, whichever occurred first

Children's Autism Program
Family Cost Share Attestation Worksheet

Instructions to Contractors: If the family has an income tax return, use the adjusted gross income to determine the cost share. If the family does not have an income tax return, complete this form with the family to determine the annual income and deductions for the family. The parent or guardian of the child must sign the form attesting to the contractor that the information they provided on this form is correct.

Gross Income for the Year

Total all the income received by the individuals included in the family size, from whatever source, that is considered income by the Internal Revenue Service before federal allowable deductions are applied. A copy of the family's paycheck stubs or other forms of documentation need to be submitted with this form to confirm gross income reported.

Income Type	**Parent 1**	**Parent 2**	**Child and Other Dependent(s)**	**Total**
Wages, salaries, tips				$
Self-employment income				$
Unearned income such as retirement benefits or child support				$
Unemployment benefits				$
Dividends and interest				$
Other: SSI or other disability income such as Social Security due to disability or Veteran's disability is not countable income but make note that the family receives it.				$ 0 (not countable)
			Grand Total	**$**

Allowable Deductions

Allowable deductions include expenses not covered by insurance. The deductions may be medical or dental expenses to alleviate or prevent a physical or mental defect or illness and limited to the cost of:

- diagnosis, cure, alleviation, treatment, or prevention of disease;
- treatment of any affected body part or function;
- legal medical services delivered by physicians, surgeons, dentists, and other medical practitioners;
- medication, medical supplies, and diagnostic devices; and
- transportation to receive medical or dental care.

Allowable Deduction Type	**Parent 1**	**Parent 2**	**Child and Other Dependent(s)**	**Total**
Medical or dental expenses not covered by insurance (as determined by the above criteria)				$
Co-pays, co-insurance, and deductibles				$
Medical or dental debt that is being paid on an established payment plan				$
Childcare and respite expenses				$
Costs and fees associated with the adoption of a child				$
Court-ordered child support payments for children who were not counted as family members or dependents in calculating the adjusted income and family cost share amount				$
			Grand Total	**$**

Adjusted Income (used to determine Family Cost Share)

Gross Income	**$**	**- Allowable Deductions**	**$** -	**= Adjusted Income**	**$**

I attest the information included on this form is correct.

Parent (or guardian) signature: ________________________________ Date: ________________________