Initial Intake Packet

Dear Parent,

Thank you for your interest in obtaining Applied Behavior Analysis services through our Ready Set Connect program. We are excited for you to join us!

It is **extremely important** that each one of these forms is filled out completely and sent back to us before your appointment date; this includes personal and insurance information, as well as any required signatures.

If you have any questions or concerns, please call us at 603-333-2880. Again, thank you for your interest. We look forward to receiving your intake information and meeting here with you at the clinic.

Clinic Information

Ready Set Connect - Concord
57 Regional Drive, Suite 7
Concord, NH 03301
603-224-7630
Fax: 603-410-1105

Ready Set Connect - Tilton
580 Laconia Road
Tilton, NH 03276
603-527-8620
Fax: 603-410-1105

Ready Set Connect - Manchester
1750 Elm Street Suite 112
Manchester NH 03104
603-792-0077
Fax: 603-410-1105

Admissions and Insurance Contact Information

Natalie Kitching-Rajak
Insurance & Billing Manager
Nkitching@readysetconnect.org
603-333-2880

Katherine Dunn
Admissions & Billing Specialist
Kdunn@readysetconnect.org
603-333-2888

Initial Intake Packet Documentation

Please complete the following steps prior to your child's visit:

Letter Of Medical Necessity

Please provide a letter of medical necessity, and a copy of the diagnostic evaluation, from the diagnosing provider.

- Insurance companies require a letter from your child's physician stating that he/she has been diagnosed with autism, and that ABA services are medically necessary.
- Diagnostic evaluation from provider that diagnosed your child with autism.

Information Forms

Please provide a copy of all forms completely filled out, signed and dated.

- Intake Information Form
- Insurance Information Form
- Scheduling and Services Information Form
- Medical Information and Family History Form
- Request and Authorization for Pick-up Form
- Request and Authorization to Exchange Information Form
- Policy and Consent Information Form

Acknowledgement Forms

Please provide a copy of the acknowledgement forms completely filled out, signed and dated.

- Parent Responsibility Coverage Knowledge
- Privacy Notice
- Parent / Guardian Handbook Acknowledgment

Insurance authorization

Please call your insurance carrier to confirm ABA is covered by your plan.

- There may be co-pays or coinsurance you are responsible for.
- Provide copies of all insurance cards front and back.

Letter of Medical Necessity Sample

Please note: This is a sample and the physician's letter must be written on an official letter head.

Date:

To Whom it May Concern,

I'm the (title and name) who had provided care to child's name from 20__ to present.

Child name was diagnosed with autism F84.0. He/she currently meets the diagnostic criteria for autism disorder F84.0. Especially he/she shows list whatever criteria you think they exhibit:

- Marked Impairment in the use of nonverbal behavior
- Failure to develop peer relationships.
- Lack of spontaneous seeking to share interests.
- Laco of social or emotional reciprocity
- Delay in development of spoken language
- Stereotyped and repetitive language
- Lack of social imitative pal and inflexible adherence to routines or rituals

Applied Behavioral Analysis (ABA) is the best established most evidence base approach for the treatment of autism spectrum disorders. An intensive ABA program is medically necessary for the treatment of autism because its effectiveness has been clearly established through well-controlled scientific studies. Research has shown that ABA Therapy helps to address the behaviors, speech/language/communication impairments, and social difficulties that children with autism spectrum disorder exhibit.

Therefore, intensive ABA therapy services are medically necessary for child name to ameliorate child's name condition of autism by improving his/her functional level.

Name, Title, and Date

Please note: The letter must be signed by the diagnosing doctor and or PCP of the child.

READY SET CONNECT
AUTISM CENTERS

Intake Information Form

Personal Contact Information

Client's Name:	*Date of Birth:*
Address:	*Gender:*

Parent / Guardian Information (1)

Parent / Guardian Name:	*Relationship to Client:*	*Phone Number:*
Address:	*E-mail:*	

Parent / Guardian Information (2)

Parent / Guardian Name:	*Relationship to Client:*	*Phone Number:*
Address:	*E-mail:*	

Emergency Contact

Name:	*Relationship to Client:*	*Phone Number:*
Address:	*E-mail:*	

Referring Diagnosis

Diagnosis:

Referring Provider(s) Information

Provider Name:	*Provider Name:*

Location of Choice

☐ *Concord*	☐ *Manchester*	☐ *Tilton*

READY SET CONNECT
AUTISM CENTERS

Insurance Information Form

Primary Insurance Information

Insurance Company Name:		*Address:*	
Phone Number:		*Policy Holder's / Guarantor Name:*	
Policy Holder's Birth Date:		*Policy Holder's Social Security Number:*	
Policy Holder's Employer's Name:		*Annual Insurance Deductible:*	
Insurance Co pay:		*Max out of Pocket:*	
Prefix:	*Suffix:*	*ID #:*	*Group #:*

Secondary Insurance Information

Insurance Company Name:		*Address:*	
Phone Number:		*Policy Holder's / Guarantor Name:*	
Policy Holder's Birth Date:		*Policy Holder's Social Security Number:*	
Policy Holder's Employer's Name:		*Annual Insurance Deductible:*	
Insurance Co pay:		*Max out of Pocket:*	
Prefix:	*Suffix:*	*ID #:*	*Group #:*

I attest that my personal information is correct and filled out completely.

Parent / Guardian Signature:	*Date:*

Policy and Consent Information Form

Telephone Message Policy

We will leave messages at the telephone numbers listed unless otherwise indicated. All messages respect your confidentiality.

Payment information and policy

You have the option of paying for the clinic visit privately or procuring payment through your insurance carrier (when applicable). Not all of the services offered by our clinic are covered by all insurance plans. It is your responsibility to ensure that your plan covers the service that you have requested. We will be contacting your insurance carrier to verify your coverage.

Signature section

Your signature is required for the reasons explained in the three paragraphs that follow. Please read these paragraphs, and sign on the line at the bottom if you agree to these conditions. Please do not hesitate to contact us with any questions or concerns you may have about this section.

Authorization of release of information

I authorize the Ready Set Connect LLC ABA services to send a copy of any report to the primary care physician, and/or to the referring physician, as indicated on the reverse side of this page.

Authorization to be treated for assessment and treatment

I agree to be evaluated and treated, or to have my child/dependent for assessment and treatment, by an ABA Therapist/ BCBA. I understand that I can revoke this agreement at any time.

Assuring payment through your insurance plan / Parent Responsibility

You have the option of paying for the clinic visit privately or procuring payment through your insurance carrier (when applicable). Not all the services offered by our clinic are covered by all insurance plans. It is your responsibility to ensure that your plan covers the service that you have requested. We will be contacting your insurance carrier to verify your coverage at intake. It is the parent's responsibility to obtain verification of benefits as well as to verify your out-of-pocket costs and coverage. Benefits can change frequently, it is the parent's responsibility to notify RSC of any benefit changes including but not limited to any inclusion, exclusions and or any in and out of network changes. Insurance benefits are the parent's responsibility. If your child changes providers (BCBA's) RSC will notify you a week ahead of the change, it would be highly suggested that you contact your insurance to ensure the BCBA is in network, if they are not in network, you will be responsible for all accrued costs. An insurance authorization is not a guarantee of payment, and parents will be responsible for paying any remaining balance not covered by insurance and or any service not covered by insurance.

Parents are responsible for notifying Ready Set Connect, DHHS (if you Medicaid) and their health plan if anyone else is responsible for paying their medical bills including other insurance. Parents also must ensure that all benefits for all insurances are always coordinated appropriately with perspective

insurances. Parents are responsible for notifying RSC of any address and insurance changes before they occur. It is not RSC responsibility to manage your medical benefits this is the responsibility of the parent.

Parents are responsible for all copays, coinsurances, non-covered services, cancellations, and appointments that are not honored by your insurance company. Parents will take full fiscal responsibility for any balance occurred due to not reporting insurance changes and or because of any insurance processing problems. Insurance at times will send payments to parents, parents are to notify RSC of any payments sent to them and are not to cash those checks. If the checks are cashed by families the balance will be billed to the family for those services and be due within 30 days of the statement. If an unpaid balance of $500 is accrued, services will be placed on hold until the balance is paid in full. Parents are expected to pay each statement in full within 30 days of the statement date.

Emergency Events

In the event of an emergency requiring hospital treatment, every effort will be made to contact parents (person Otherwise designated) before any action is taken. Please note that children will be taken to the closest hospital in the event of an emergency.

Cancellation and No-Show Policy

Appointments must be canceled a minimum of 2 hours in advance. I understand if I fail to cancel an appointment without sufficient notice or if I fail to show for a scheduled appointment, and or am 15 minutes late for my scheduled appointment. I will be charged $25.00. I understand these fees need to be paid within 30 days of the invoice.

Medicaid Verification

Parents need to provide notice of decision from New Hampshire DHHS verifying that they have active Medicaid coverage at intake. After intake this will be an expectation yearly and or based on your case it might occur more frequently. Parents will need to provide the notice of decision to RSC each year at their redetermination date. Please note if your household changes and your medical coverage / benefits for your child's Medicaid /MCO change you will want to notify the billing and insurance manager immediately of this change before the insurance terms. If you have a change in your family or household income the state will change your coverage before the yearly redetermination. ABA therapy is authorization based, and RSC does not accept straight Medicaid, RSC only accepts NHHF, Wellsense and AmeriHealth for Medicaid Mco's.

I certify that I have received a copy of the Policy and Consent Information form.

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*

Scheduling and Services Information Form

Schedule

Please fill out the table below with your child's **preferred schedule** (This table will show us what you want their time at RSC to look like)! This is a way for our schedulers to see incoming client requests. (Please note these are requests. Each child's time at RSC is based off medical necessity which is determined after the initial assessments are done by a BCBA).

RSC Hours of Operation are Monday - Friday 8:00AM - 5:00pm. If you do not wish to have your child attend Monday through Friday, please put NA on the day's not attending. A client's hours will be based on medical necessity. Children under the age of 6 years old typically come between the hours of 8 am - 3 pm. School-aged children come 3 pm - 5 pm, with a minimum of two evenings a week.

Day of the week	***Drop off at RSC (Time)***	***Pick up from RSC (Time)***
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

School Contact Information

School Name:	*School Phone Number:*
School Address:	*Teachers Name:*
Name of other contact person who knows your child:	*Does your child have a current IEP?*

If your child has an IEP, please provide a copy of the current IEP with the intake paperwork.

School Schedule and Services

Type of Services in School:	***Hours per week:***	***Schedule Of Services:***
School Hours per day		
Paraprofessional		
Speech		
Occupational Therapy		
Physical Therapy		

Early Intervention Services

Early Intervention Services:	***Hours per Week:***	***Site of Therapy:***
Home visitor		
Center-based individual visit		
Child play group		
Parent support group		
Other (please describe)		

Therapeutic Services

Therapeutic Services:	***Hours per week:***	***Site of Therapy:***
Individual speech therapy		
Group speech therapy		
Occupational therapy		
Physical therapy		
Counseling or psychotherapy		
Social skills group		
Other therapies		

Medical Information and Family History Form

General Medical Information

Please List any Parental Concerns:

Medical, Developmental, or Mental Health Diagnoses (Diagnosed or Possible):

Diagnosis	*Diagnosis Date*	*Provider Name*	*Do you Agree?*

Medications

Please list any medications taken, please include dosage and frequency:

Allergies

Please list any allergies:

Family History

Does anyone in the child's family (blood relatives) have any of the following conditions? **Diagnosis**	**Which Family Member has this Diagnosis?**
Learning disability	
Attention deficit disorder	
Autism or PDD	
Intellectual or Developmental Disorder	
Cerebral palsy	
Birth defect	
Epilepsy	
Chromosomal abnormality	
Vision impairment	
Other developmental disability	
Depression	
Psychosis	
Bipolar disorder	
Anxiety	
Any Chronic Infectious disease	

Request and Authorization for Pick-up Form

Your child will be released only to the person(s) listed on your authorization form. Please advise family and friends who occasionally pick up that identification will be required.

Please notify the office if there are any changes in pick-up plans or arrangements or changes to the authorization.

Childs Name:		
Name:	*Relation:*	*Phone:*
Name:	*Relation:*	*Phone:*
Name:	*Relation:*	*Phone:*
Parent Signature:		*Date:*

Privacy Notice

This Notice was published and became effective April 14, 2003. Ready Set Connect reserves the right to amend this Notice. All changes will be made known to you via a revised notice.
This document is available in an alternative format upon request.

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

Please read and return this notice to Ready Set Connect LLC. Your signature is required before services can be initiated.

Ready Set Connect LLC respects your right to privacy, especially related to your personal health information. To ensure your privacy, all employees, contracted providers, volunteers, and companies performing business functions for Ready Set Connect LLC will treat personal and identifiable health information with the utmost confidentiality. Ready Set Connect is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to inform you of our legal duties and privacy practices with respect to your health information.

How Ready Set Connect May Use or Disclose Your Health Information

1. Ready Set Connect LLC will need to utilize and release personal health information for treatment, payment, and healthcare operations. A) Treatment - We will use your health information to provide the evaluation and consultation services you have requested. We may disclose your health information to Ready Set Connect therapists and other persons involved in providing or coordinating your services. B) Payment - We may use and disclose your health information so that your assistive technology services may be billed to, and payment may be collected from you, an insurance company or a third party. C) Healthcare Operations -We may use and/or disclose health information in connection with our own quality assessment activities and for training and supervision of staff members.
2. We will share your protected health information with third party "business associates" performing various activities that are essential to the operations of our organization. The release of confidential information to business associates will occur only when necessary to provide the services you requested or to process essential functions such as billing, accounting, quality assurance, or legal and financial activities.
3. The staff of Ready Set Connect LLC may use confidential information to provide you with appointment reminders or information related to treatment alternatives. Additional activities may include the assessment and design of program activities and/or to generate informational mailings. A consumer may request to be removed from the Ready Set Connect mailing list by simply calling the privacy officer at 800.932.5837.

4. We will disclose health information about you when required by federal, state, or local law.
5. We may disclose health information related to adverse events with respect to product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement,
6. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
7. We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and, in certain situations, in response to a subpoena, discovery request or other lawful process.
8. We may disclose health information for the following specific government functions: a) health information of military personnel, as required by military command authorities; b) health information of inmates, to a correctional institution or law enforcement official; and c) in response to a request from law enforcement, if certain conditions are satisfied.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described in this Notice. You may revoke this authorization, at any time, in writing, except to the extent that we have already relied upon your authorization in making a disclosure.

How We Will Protect Your Personal Health Information

1. Strict policies and procedures related to privacy will be followed when using computerized information, electronic mail, facsimile transmissions, voice mail and the storage of confidential records.
2. To protect personal health information from unauthorized or accidental release policies dictate the following:
    a. Your written consent or that of your legal representative (only) is required to release information to anyone not otherwise authorized by law to receive it.
    b. Requests for information related to mental illness, substance abuse, genetic testing results, HIV, or AIDS cannot and will not be released or re-released without a written consent from you or your legal representative.
    c. Our Business Associates, who receive protected health information, will be required to sign a Business Associates Agreement, which obligates them to follow procedures necessary to protect confidential identifiable health information and to use the information only for the stated purpose identified in the agreement.

Your Rights Regarding Your Health Information

1. You and/or your legal representatives may review the contents of your chart and obtain a copy (for a fee) after a written request is submitted. All reviews of a consumer chart will be conducted in the presence of a Ready Set Connect LLC staff member.

2. You are entitled to receive confidential information about your protected health by alternative means or at alternative locations. Please call the privacy officer to make such a request.
3. You and/or your legal representative may submit a written request to amend your protected health information to correct an inaccuracy or to improve clarity. All requests will be processed according to the organization's policies and procedures. Please note that Ready Set Connect LLC is not obligated to agree to the requested amendment, but we are required to consider the request and inform you of our decision.
4. You and/or your legal representatives may obtain the disclosure history of your personal health information.
5. You and/or your legal representative may request, in writing, to restrict disclosures of personal health information, although Ready Set Connect LLC is not obligated to agree to the requested restriction. We are, however, required to consider the request and inform you of our decision.

If you believe that your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Direct Complaints Regarding the Violation of Privacy Rights to:

Privacy Officer - Ready Set Connect LLC
- or -
Secretary of the United States - Department of Health and Human Services

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How Ready Set Connect May Use or Disclose Your Health Information

Ready Set Connect respects your right to privacy, especially related to your personal health information. To ensure your privacy, all employees, contracted providers, volunteers, and companies performing business functions for Ready Set Connect will treat personal and identifiable health information with the utmost confidentiality. Ready Set Connect is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to inform you of our legal duties and privacy practices with respect to your health information. Ready Set Connect will need to utilize and release personal health information for treatment, payment, and healthcare operations.

A. Treatment - We will use your health information to provide the evaluation and consultation services you have requested. We may disclose your health information to Ready Set Connect therapists and other persons involved in providing or coordinating your services.
B. Payment - We may use and disclose your health information so that your assistive technology services may be billed to, and payment may be collected from you, an insurance company or a third party.
C. Healthcare Operations - We may use and/or disclose health information in connection with our own quality assessment activities and for training and supervision of staff members.
    1. We will share your protected health information with third party "business associates" performing various activities that are essential to the operations of our organization. The release of confidential information to business associates will occur only when necessary to

provide the services you requested or to process essential functions such as billing, accounting, quality assurance, or legal and financial activities.

2. The staff of Ready Set Connect may use confidential information to provide you with appointment reminders or information related to treatment alternatives. Additional activities may include the assessment and design of program activities and/or to generate informational mailings. A consumer may request to be removed from the Ready Set Connect mailing list by simply calling the privacy officer at 800.932.5837.
3. We will disclose health information about you when required by federal, state, or local law.
4. We may disclose health information relative to adverse events with respect to product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
5. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
6. We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and, in certain situations, in response to a subpoena, discovery request or other lawful process.
7. We may disclose health information for the following specific government functions:
   a) Health information of military personnel, as required by military command authorities.
   b) Health information of inmates, to a correctional institution or law enforcement official.
   c) In response to a request from law enforcement if certain conditions are satisfied.

Uses and Disclosures of Protected Health Information Based on Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described in this Notice. You may revoke this authorization, at any time, in writing, except to the extent that we have already relied upon your authorization in making a disclosure.

I certify that I have received a copy of the Privacy Notice, dated April 14, 2003.

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*

Telemedicine Consent

Parents are encouraged to call their insurance and verify which place of services your insurance covers as well as telehealth benefits. It is not a guarantee that telehealth will be covered, and you will want to notify RSC if you have the coverage or not at intake. It is also the responsibility of the parents to check yearly to ensure that telehealth is still a covered service. All costs associated with telehealth are parents' responsibility.

I, consent to my child receiving Telemedicine in the use of interactive audio, video, or other electronic media for the purpose of consultation, parent training and BCBA supervision treatment.

Parent / Guardian Signature:	*Date:*

Parent Responsibility Coverage Knowledge Form

Parents (or legal guardians) are ultimately responsible for knowing and understanding their child's insurance policy, including any requirements related to autism services, like the need for a Comprehensive Diagnostic Evaluation (CDE). Here is a clear breakdown of what that responsibility involves, and what you can do to manage it.

Knowing What's Covered

You need to understand:

- Whether your plan covers ABA therapy, coverages including telehealth and in/out of network status
- What requirements are tied to those services (e.g. a diagnosis from a specific type of provider, severity levels, or recertification timelines).
- If a recent CDE (e.g. within 3 years) is required for authorization or continuation of services

Keeping Track of Documentation

- You should know when your child's last CDE was completed.
- Keep a copy of the diagnostic report, as it may be needed for reauthorization or appeal

Understanding Plan-Specific Rules

- Each insurance plan (even under the same company like Blue Cross) can have different:
- Coverage levels
- Network restrictions
- Reevaluation requirements
- Prior authorization procedures
- That means what's true for one family may not apply to another, even with the same insurer.

Communicating With Providers

- Your ABA provider, therapist, or pediatrician may remind you about upcoming expirations of documentation, but it is not legally their responsibility to ensure your paperwork is up to date.
- Some providers help manage this, but if something is missing, the claim denial will affect your child, not the provider.

Staying Ahead of Reauthorization

- If your plan requires a new CDE every 3 years, it's your responsibility to schedule it in advance, since waitlists for autism evaluations can be long.

Communication Surrounding Insurance change:

ABA Authorization is Plan-Specific. A new insurance plan does not automatically transfer authorization from the old one. Each insurance plan has its own rules for:

- Coverage of ABA therapy
- Approved providers (in-network vs. out-of-network)
- Prior authorization process
- Required documentation (e.g. CDE age limit, treatment plan format)

Delays Can Cause Service Gaps

If you don't inform your provider or insurer promptly:

- Therapy may be paused until new authorization is obtained.
- Your ABA provider may not be able to bill the new insurance.
- You may have to restart the entire approval process, which can take weeks or months.

You May Be Liable for Costs

If services are provided without updated authorization under the new insurance:

- The claim may be denied.
- You (the parent/guardian) may be billed in full.
- Retroactive authorizations are not guaranteed, especially with Medicaid or strict commercial plans.

When to Notify

- Immediately after you know your insurance is changing
- Before the current plan ends or the new one starts
- As early as possible if there's a known gap (e.g. job switch, open enrollment)

Who to Notify

- Your ABA providers Billing and Insurance Manager – Natalie Kitching-Rajak
- New insurance company (to verify benefits and ask for coverage rules)
- Behavioral health case manager (if assigned)
- Old insurer (if they're still processing claims, or if COB is required)

I certify that I have received a copy of the Parent Responsibility Coverage Knowledge Form.

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*

Parent / Guardian Handbook Acknowledgment Form

I acknowledge that I have received, read, and understand the Ready Set Connect Parent Handbook. I agree to follow the policies and procedures outlined in this handbook and understand that they are designed to provide a safe, structured, and supportive environment for my child. I understand that if I have any questions or concerns, I can contact my child's team for further clarification.

Client's Name:	
Parent / Guardian Name:	
Parent / Guardian Signature:	*Date:*