ADAPTIVE SKILL BUILDING

Service Agreement

Please read each of the statements below. If you understand the statement and agree to the intervention service as described, please provide your initials and sign below. This Service Agreement must be completed prior to reviewing your child's application for ASB services.

Child's Name: _____Child's Date of Birth: _____

☐ I understand that the Adaptive Skill Building (ASB) program is paid for by the New Mexico Department of Health (DOH). I understand that the Center for Development and Disability (CDD) at UNM manages the program.

☐ I understand that ASB services will not be provided directly by the CDD, but will be provided by an agency within my community that works with the Department of Health.

☐ I understand that the ASB program will provide Applied Behavior Analysis (ABA) to my child, and I have read the description of ABA that was provided to me.

☐ I understand that this is a "fill-in-the-gaps" program that was set up to provide ABA services to children who have no other way of getting ABA. I understand that services are limited to a *maximum* of 10 hours per week for *no more than* 2 years because there are a lot of children who need services and there are limited funds to support the program. Also, I understand that while it is hoped that my child will get 2 full years of services, a change in funding or a change in provider availability may make this impossible.

☐ I understand that the program provides a minimum of 6 hours and a maximum of 10 hours per week of services for my child. I understand that if I cannot commit to at least 6 hours per week (during the summer months *and* school year), this program may not be a good fit for my child and family. Also, I understand that as long as the agency provides my child with an average of 6 hours of services per week, the agency is following the program's requirements. In other words, I understand that my child may not receive the maximum of 10 hours of weekly services. My child may receive less than 10 hours of services per week because of my family's schedule, staff availability, my child's needs and tolerance for participating in sessions, and/or other factors.

☐ I understand that ASB services will be provided in my home, or in other places in the community to meet my child's needs (for example, at a park, library, or store). I understand that while school may be an important place to provide services for my child, the agency is not allowed to spend more than 6 hours

per year in my child's school. Because of this, I understand that the ASB program may not focus on needs or concerns that I have about my child's academics or school-based education.

☐ I understand that, whenever someone is working with my child, it is expected that I be there. I understand that ASB staff will teach my child, and they will teach me how to help him/her too. I understand that I will learn how to help my child by watching sessions, receiving coaching and feedback from staff, and trying things that staff are doing. I understand that my child will have the best chance for success if I am involved in my child's services. I understand that if I cannot be there for sessions, another adult caregiver must be there.

☐ I understand that, since services are provided in my home, I must make sure that my home is a safe place. If the agency feels that my home is not safe or is not the right place to work with my child, I understand that they will work with me to help make my home safe or find another place in the community where they can work with my child.

☐ I understand that even though I may want the person who works with my child to be a certain age, gender, race, ethnicity, etc., the agency may not have someone like this available. I understand that every effort will be made to provide my child with a service provider who speaks the language we speak in our home.

☐ I understand that I need to let the agency know if anything important changes in my child's life. I understand that the agency needs to know about changes in my child's life because these changes might affect my child's success in the ASB program. I understand that important changes include: changes in medication; changes in how much or how well my child sleeps; changes in school services/placement; changes in other therapy services; and any other changes that might affect my child's learning and behavior.

☐ I understand that it may be possible to stop services for a short time if there is a family emergency, move, etc. Also, I understand that the agency may need to stop services for a short time if they lose a staff member without warning. I understand that the CDD must approve this in advance. If approved, the CDD will place my child's case "on hold" until services can continue. If services are put on hold, the agency may be able to extend services so that my child is able to stay in the program for up to 2 full years.

☐ I understand that my child will be accepted, or not accepted, into the ASB program based on information that I provide when applying. I understand that, if my child is approved and then something changes, I must let the CDD know. Specifically, I must let the CDD know if (a) my child's diagnosis changes, (b) my child's insurance/Medicaid status changes, or (c) if my child is approved for financial support through a waiver program. I understand that a change in diagnosis, insurance, or waiver status may make my child ineligible for this program. Also, I understand that, if my child is *not* approved and then something changes (for example, he/she is given a medical diagnosis of ASD, or he/she has a change or loss of insurance), I am strongly encouraged to let the CDD know so that they can reconsider my child's application.

☐ I understand that eligibility for this program is based, in part, on my child's current level of functioning. I understand that if my child's level of functioning changes, and my child needs a higher level of care than when services started, my child may no longer be eligible for this program. In other words, if intensive, specialized treatment is needed to make sure that my child, and others, are safe then this program may no longer be a good fit for my child.

☐ I understand that I must tell my ASB provider if my child is receiving therapy services from another provider. I understand that I must give permission for service providers to share information with each other, if they are working on similar goals. I understand that it is very important for providers to talk to each other so that everyone works on the same goals in the same way. I understand that, if I do not give permission for my child's service providers to share information, my child's ASB provider can stop providing treatment.

☐ I understand that all paperwork that I provide when applying for this program will be given to my child's ASB provider, if my child is approved for the program.

☐ I understand that, if there is more than one agency within my community, my child will be randomly matched to an agency. I understand that if I do not want services from that agency, I may choose to go back on the waiting list; however, I understand that my child will be placed at the bottom of the list.

☐ I understand that the person working with my child will have (a) passed a criminal history screening, (b) earned at least a high school diploma, and (c) received basic training in different areas, including: CPR, First Aid, Autism Spectrum Disorders, Applied Behavior Analysis, and other training that will help them work with my child. I understand that this person will be supervised by someone who has (a) at least a master's level education in a clinical field (e.g., psychology, counseling, speech-language pathology, etc.), and (b) clinical experience and training in providing ABA services.

☐ I understand that although there are certain Department of Health (DOH) rules that ASB agencies must follow, each agency has its own policies too. I understand that I may be asked to fill out other forms and sign other agreements. I understand that it is up to me to follow the agency's rules about setting up sessions, cancelling appointments, etc.

☐ I understand that agencies are required to write a Service Plan, Quarterly Reports, and an Exit Summary for my child. I understand that these reports are given to the CDD to review. I understand that I can ask the CDD or my child's service agency to see these reports.

☐ I understand that staff from the agency, CDD, and DOH may share information with each other so that services for my child can be provided, managed, and funded. I understand that, in most cases, information will only be shared with other people if I give my written permission. However, I understand that there are certain times when information cannot be kept private. I understand that the law requires staff to file a report whenever they have access to information about (a) someone being a danger to themselves or others, (b) someone being in an unsafe or dangerous situation because of abuse or neglect, or (c) someone being taken advantage of.

☐ **I understand that I should *not* sign this form if *anything* in this Service Agreement is not clear. Instead, I understand that I should contact the ASB program at 1-800-270-1861 to speak with someone about this service.**

_____ _____

Signature of Legal Guardian Date

_____

Printed Name of Legal Guardian

Confirmation of Agreement by Service Provider

(To be completed following case assignment.)

I acknowledge that my child's assigned service provider, _____, has reviewed this Service Agreement with me before initiating services. I confirm that I agree to receive ASB services as described. All of my questions and concerns have been addressed, and my family is ready to proceed with intervention.

_____ _____

Signature of Legal Guardian Date

_____

Printed Name of Legal Guardian

_____ _____

Signature of Service Provider Date

_____

Printed Name of Service Provider