Garner Behavior Services
Therapy and Resource Center
New Client Referral Packet
for Parents and Caregivers

2023

Dear Parent/Caregiver,

Thank you for your interest in GBS as a therapy provider for your child with autism! We understand this can be a stressful and confusing time for parents and hope to make the process as painless as possible for you. GBS is also available to answer any questions we can for you as you embark on this journey.

GBS is a 1:1 ABA therapy Center. We provide each child with a one-to-one therapist who is specially trained in applied behavior analysis to help your child learn new skills and to help your child find better ways to express frustration in place of problematic behaviors. Our therapy sessions are conducted at one of our two centers. We have a center in Williamsport, at 138 Catawissa Avenue, and one in Lewisburg, at 1722 West Market Street, Suite 4. Our sessions run from 9 to 2pm, Monday through Friday.

Our sessions are long, as most children attend the full 25hrs a week, because research has shown that 20+ hrs of ABA has been the most effective in developing the skills your child needs, such as communication, playing with others, following routines, toilet training, etc.… and in reduction of problematic behaviors that interfere with learning. All sessions are provided on site, providing continued supervision of therapists, and ample opportunities for social interaction with other clients.

Our day mimics a preschool schedule with instructional table time (depending on individualized needs of each client). We do calendar, circle, art, snack, lunch, play, games, and all the activities your child would experience in a daycare or preschool, but with a 1:1 therapist who can use each moment and activity to help your child learn and grow. Each child has his/her own personalized assessment and learning plan (ITP) that focuses on your child's specific communication, socialization, play, and behavior needs.

Due to providing a therapeutic service, GBS does not permit other therapies to take place on site at the same time as our services. You may have to adjust your child's schedule or speak to GBS about available schedule changes. <u>GBS is also not a preschool, daycare, does not offer transportation, naps, summer camp, ESY, and is not a counseling center.</u>

Our clients at the center range from ages 2 through 6, as it is our mission to help these young children reach their potential before entering school. As they get older and skills increase, we may recommend a part time daycare or preschool in addition to GBS, or home hours for community therapy, to help generalize the skills we have taught. In addition, YOU are a vital component of your child's therapy! Parents receive daily session notes and weekly summaries and are welcome to schedule to come in and view their child's program book, speak with their Consultant, or receive additional training.

If you would like your child to be added to our short wait list (typically 1-4 months), please submit the following materials:

1. A copy of the front and back of all your child's medical insurance cards.
    a. We need a copy of all of your child's medical insurance cards, through MA if your child has Medical Assistance, and through your work, if your child is on insurance through your work. These can be faxed, emailed, or mailed to the address listed below.

2. The name, address and date of birth that the insurance is under (if the insurance is under a parent, we need the parent's information) for each insurance card.
    a. The last page of this document is where you can place this information. That page is a "summary page" that must be submitted with the rest of the information requested. Our biller needs this information in order to request services for your child.
3. A completed written order form (sample included in this packet)
    a. Please take the copy of the written order to your child's doctor or to the doctor that conducted the psychological evaluation. This form MUST be signed and completed by a PA licensed professional such as a MD, Psychologist, Psychiatrist, or CRNP. We cannot provide services without this form being completed.
    b. The written order is for the MAXIMUM of hours that can be provided. This may not the actual number of hours your child will be prescribed or will actually receive. It is only the maximum allotted.
4. A copy of the most recent psychological evaluation. This evaluation must state an "autism" diagnosis to receive services and needs to have been conducted within the past 2 years. A school evaluation is not acceptable.
    a. You can request the psychological evaluation from the evaluator. It is usually 5-12 pages long and will include background information, testing information and diagnosis. The evaluator may also fax this form to GBS (number below).
5. The Child's birthday/Age
6. Parent names, address
    a. Please provide GBS with legal guardian names, addresses, and dates of birth. If there are legal circumstances, please provide information.
7. Contact information
    a. GBS needs adequate contact information, typically email, for exchange of materials and notices.

You can send the information to our confidential email at **drgarner@gbsautism.com**

Or you may email a package to **PO BOX 5082 South Williamsport, PA 17702**

Or you may fax materials to **570-209-5763**

All of these materials must be received *before your child can be added to our wait list*. Our wait list does not necessarily go in order but may depend on the location of clients and staffing availability. We also recommend that you schedule a tour, as we feel it is important for parents to see where their child will be receiving therapy and meet our staff. GBS will not schedule a tour until all materials have been submitted.

<u>Time line/Process</u>: (this whole process can take 1 to 4 months, depending on staff availability and when materials are submitted)

1. Submission of all required materials
    - Written order
    - Psychological evaluation
    - Insurance cards
    - Online intake form

   - Client information sheet
   - *Point 1 duration depends on the parent/caregiver and accuracy of information provided. A sample of what is needed in the Written Order is provided for your doctor.*
2. GBS staff will schedule with parents to review and sign our Service Agreement
   - Typically takes 2 hrs, completed at the office.
   - *Point 2 will take place within 1 month of materials being submitted*
3. Clinician schedules to begin assessment process. This will include interview, observation and testing. Assessment is conducted across environments (ie, home visits will be required)
4. Clinician uses information from assessment, interview and reports to develop your child's Individualized Treatment Plan (ITP).
5. Clinician schedules an appointment to review ITP with parents/caregivers and to get ITP signed
   - *Points 3-5 must be completed within 30 days*
6. ITP is sent to insurance for approval for services
7. Upon insurance approval, GBS assigns a technician
   - When a trained technician is available, the child begins services on site.
   - *Point 7 may take 0-4 months, depending on staff availability*

If you have any further questions, please call 570-435-8180

Thank you, and we look forward to hearing from you!

Dr. Dana Garner, BCBA-D

drgarner@gbsautism.com

Parent Insurance Verification Tool

(Please fill out the following form and return. Commercial insurance only

(MA/Medicaid does not need to complete this form)

Child Name: DOB: Age:

Child Address:

Caregiver Name:

On the back of your insurance card call the Mental Health/Behavioral Health phone number

Questions to Ask:

1. **Rep Name:**
2. **Date of Call:**
3. **Reference number for call:**

This is very important to document in case you are given erroneous information.

When calling your insurance many customer service reps **do not know** what ABA (Applied Behavior Analysis) therapy is. In order to assist them to obtain the right information provide the following:

1. ***Advise this is a mental health/behavioral health benefit.***
2. Provide the service that will be performed:

- BCBA Evaluation: Diagnosis:
- RBT Direct Service: Diagnosis:
- **Does my plan follow the Autism State Mandate**? Yes___ No ____
  (if yes, then your insurance follows Act 62 and has an autism benefit)

Is my plan self-funded? Yes ____ No ____

If Yes, ask if your **plan has an Autism/ABA benefit**. Yes_____ No____

Deductible:

1. **Do I have a deductible?** Yes No
   If yes,

- **What is my individual deductible for my child?** _____________
- **Has anything been met yet? Yes Amount Met _______ No**
- **What is my family deductible?** _________________
- **Has anything been met yet? Yes Amount Met _______ No**

Co-Pay or Co-Insurance

Note: Your insurance will either have a co-pay for each visit or co-insurance. Some insurances may not require co-pay or co-insurance where they will pay everything, and you will have no out of pocket costs BUT this is rare.

1. **What is my Co-Pay? __________**

2. **Is co-pay applied per provider, per day? ______________**

3. **What is my co-insurance? (Percentage insurance pays and percentage patient responsibility ___________________________________**

4. **Are visits unlimited? Yes No**
   If No, **how many visits are permitted yearly?**

Out-of-Pocket Maximums

Many insurances have a benefit that you pay out-of-pocket up to a certain maximum amount. Once you reach that maximum, the insurance will pay at 100% and you no longer have copays or coinsurance. Sometimes the deductible paid is included in the max amount, sometimes it's not. It is always best to ask.

1. **What is my Out-of-Pocket maximum?**

2. **Is the deductible applied to the OOP maximum?**

3. **What amount has already been applied to my OOP maximum?**

Lifetime or Yearly Maximums:

Some insurances will only pay up to a capped amount each year. This means that once the insurance pays all that they are contracted to pay they will STOP paying claims stating, *"benefits have been exhausted."*

1. **Is there a yearly maximum on my policy? Yes No**
   If Yes, what is the yearly maximum amount insurance will pay?

2. **Is there a lifetime maximum on my policy? Yes No**
   If Yes, what is the lifetime maximum amount insurance will pay?

Authorizations:

1. **Does my insurance require an authorization for ABA therapy?** Yes No
   If Yes, **what phone number must my provider call?**

Additional Notes:

Written Order
MUST BE COMPLETED and SIGNED by a Licensed Professional

Clinical information to support the medical necessity of the service(s) ordered:

client has a diagnosis of autism and has not shown progress in skill development or maladaptive behavior reduction in the absence of intensive center based therapy.

The measurable improvements in the identified therapeutic needs (for individual and Group Services) and/or in targeted behaviors or skill deficits (for ABA Services) that indicate when services may be reduced, changed or terminated:

	Identified Therapeutic Needs and/or Targeted Behaviors or Skill Deficits	Measurable Improvements necessary to reduce, change or terminate IBH Services
1.	Deficit in communication	Client will complete levels 1, 2, and 3 of the VB-MAPP skill assessment on communication skills, including manding, tacting, listener, echoic and linguistic skill areas as well as demonstrate a generalization of said learned skills.
2.	Deficits in socialization	Client will complete levels 1, 2, and 3 of the VB-MAPP skills assessment or other relevant social skills assessment demonstrating measurable improvements in group and social skills, interacting and relating to peers, participating in group activities, sharing, peer manding, interactive toy play, etc.
3.	Deficits in Adaptive and Daily Life skills	client will complete adaptive and daily life goals related to the following routines: eating, toileting, dressing, and self care
4.	Reduction of maladaptive and problematic behaviors that impeed learning and socialization	Following an FBA and development of functionally appropriate interventions, client will demonstrate a reduction of problem behaviors and increase functional communication.

Recommendation for Initial or Continued IBHS Treatment

A comprehensive, face-to-face assessment is recommended to be completed by an IBHS clinician to further define how the recommendations in this order will be used and to inform and complete an Individualized Treatment Plan (ITP). This order is valid for 12 months. If this order needs to be amended/updated during this 12-month period, a prescriber collaboration form is to be used.

Directions: Please select the IBHS Service Category or Categories, and the specific IBH Service Type(s) within each category that are medically necessary for the child, youth or young adult based on symptom(s) and/or behavior(s) of concern. For each service type recommended, please indicate the maximum number of hours per month (or episode if relevant) based on severity of symptoms/behaviors, and the specific setting(s) in which treatment should occur. NOTE: All sections in the same row must be completed for a service to be appropriately authorized.

Intensive Behavioral Health Service Categories (select only those which correspond to the service types being recommended)	IBHS Service Types	Maximum number of hours per month (hpm) (NOTE: The IBHS agency may provide less as clinically indicated)	Settings in which treatment is necessary
☐ IBHS Individual Services	☐ Mobile Therapist (MT) ☐ Behavior Consultant (BC) ☐ Behavior Health Technician (BHT)* *An FBA is required first	Up to ____ hpm Up to ____ hpm Up to ____ hpm	☐ Home ☐ School ☐ Community ☐ 1:1 Center-based Specify community location(s): ____
☐ IBHS Group Services		Up to ____ hpm	
✚ ABA Individual	✚ Behavior Analytic Services (BCBA) ✚ Behavior Consultant (BC-ABA) ☐ Assistant Behavior Consultant (Assistant BC-ABA) ✚ Behavioral Health Technician (BHT-ABA)* *An FBA is required first	Up to 60 hpm Up to 60 hpm Up to ____ hpm Up to 200 hpm	☒ Home ☐ School ☒ Community ☒ 1:1 Center-based Specify community location(s): ____
✚ ABA Group Services		Up to 30 hpm	
☐ EBT Services	☐ Multi-systemic Therapy (MST) ☐ Functional Family Therapy (FFT) ☐ Parent-Child Interaction Therapy (PCIT) (Select 1:1 Center-based for PCIT)	Up to ____ hpm Up to ____ hpm Up to ____ hpm	☐ Home ☐ School ☐ Community ☐ 1:1 Center-based Specify community location(s): ____
☐ CSBBH	☐ Mobile Therapist (MT) ☐ Behavior Health Technician (BHT) ☐ IBHS Group Services	Up to ____ hpm Up to ____ hpm Up to ____ hpm	☐ Home ☐ School ☐ Community ☐ 1:1 Center-based Specify community location(s): ____

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Intensive Behavioral Health Services (IBHS) Written Order Letter - All Counties

Collaboration and Confirmation

onfirm that following my recent face-to-face appointment and evaluation of this child, and after considering less restrictive levels of care, as well as the prioritization of in-network evidence-based treatments, I am making the recommendations as per the above Written Order.

Prescriber Name: ____________________ Degree: ____________________

License Type: ____________ NPI#: ____________ PROMISE ID#: ____________

Prescriber email address: ____________________

Prescriber Phone Number: *(no dashes)* [ ]

Prescriber Signature: ____________________ Date: *(mm/dd/yyyy)* [ ]

I confirm that I have participated in the face-to-face appointment and/or evaluation (for myself/my child) and understand the above recommendations for treatment under IBHS. I understand that treatment hours listed above describe the maximum amount to be received per month and that IBHS treatment hours may vary, based on clinical need and ongoing assessment.

Parent/Guardian Name: ____________________

Parent/Guardian Signature: ____________________ Date: *(mm/dd/yyyy)* [ ]

Member Name (if 14 or older): ____________________

Member Signature (if 14 or older): ____________________ Date: *(mm/dd/yyyy)* [ ]

(Please ensure all the above is signed and dated)

Garner Behavior Services, LLC

<u>Please fill out the following information and submit.</u>

Child First Name:		Child Last Name:	
Child DOB:		Child current age	______ Yrs _____ months
Parent 1 First Name:		Parent 1 Last Name:	
Parent 1 Phone Number		Parent 1 Email	
Parent 1 DOB		Parent 2 DOB:	
Parent 2 First Name:		Parent 2 Last Name:	Gentile Jr.
Parent 2 Phone Number		Parent 2 Email	
Address of client:			
Client primarily lives with Parent 1 _____ Parent 2 _______ both parent 1 and parent 2 Other:			

	Insurance 1 (Primary)	Insurance 2 (Secondary)
Insurance		
Insurance ID#		
Subscriber:		
Subscriber Date of Birth:		
Primary Center Assignment:	Williamsport _________ Lewisburg __________ *Telehealth ________	

**Telehealth option only available if client is 60min drive time or more from GBS centers*

Potential Schedule for Center or Home based Sessions:

Mon-Fri 9-2pm	*Yes No*	*2-3 days a week 9-2pm*	*Yes No*
½ days, 9-noon, my child naps/is 2 yrs old	*Yes No*	*I need to discuss a schedule not listed*	*Yes No*
I am interested in additional home hrs: (please list days/times)	*Yes No* *If yes, these are the days and times I would be available:*		

Contacts:

Fax: 570-209-5763
Email: Drgarner@gbsautism.com
Mail: Po Box 5082 South Williamsport, PA 17702
Phone: 570-435-8180 (main office)