Thank you for your interest in Carle Auditory Oral School's Outreach Program!

Attached you will find the documents required to complete our intake process. Please print, complete, and return the documents. If you do not have access to a printer, please share your mailing address and we will send a packet to you in the mail. Forms can be returned by scanning and emailing the forms to me at Danielle.Chalfant@carle.com or by mailing them to us at Carle Auditory Oral School, 611 W. Park St., Urbana, IL 61801 ATTN: Outreach Intake Forms.

- Outreach Information Form
- Consent for Tele-Intervention
- Consent to Use Google Drive
- Tuition Express Information Forms

The Outreach Information Form allows us to collect contact information and communication preferences for our outreach families to help us to stay connected with you moving forward. There is a section for you to share information about members of your child's household as well. We have included this section because children often share stories about parents, siblings and other members of their household during therapy and having the names and ages up front helps us to be better communication partners. The third section of the form asks for contact information for other members of the child's team so that we can collaborate with them to ensure that your child's learning is as effective, relevant and efficient as possible. We offer a variety of Outreach Support services. Some are billed to insurance, others are billed through therapy tuition. Please complete the bottom section of the form if you are planning to access our therapy tuition sliding scale.

The Consent for Tele-Intervention documents your consent for your child's outreach services to be provided using Zoom.

The Consent to Use Google Drive documents your consent for the creation of a folder on the google drive which contains your child's outreach goals, documents progress toward those goals, and allows for consistent collaboration between individuals who have access to the drive.

Families that access the therapy tuition sliding scale have the option of making monthly payments by check, or to use our Electronic Funds Transfer payment option. After your intake packet is reviewed, I will be in touch to discuss your cost per session and approximate billing dates. If you choose to use Tuition Express, the Tuition Express Information Forms attached to this email provide information about how Tuition Express works and includes a form where families can enter their routing and account information to allow for deductions to occur. **Families will be billed for all scheduled sessions.** Please let us know if you have any questions about these payment options by contacting Myra Fawbush (Myra.Fawbush@carle.com) and Danielle Chalfant (Danielle.Chalfant@carle.com). We look forward to hearing back from you!

Sincerely,

Danielle M. Chalfant, Director
Carle Auditory Oral School

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Carle

Outreach/Therapy Information Sheet

Child's Name:_____ Birth Date:_____

In the event that we need to communicate with you during the day, please rank your preferred method of communication in the spaces provided below, with "1" being the primary mode of communication:

ADULT 1:		ADULT 2:	
Name:		Name:	
Address:		Address:	
City/Zip:		City/Zip:	
Cell Phone:		Cell Phone:	
Text OK? ☐ Yes ☐ No	List Carrier:	Text OK? ☐ Yes ☐ No	List Carrier:
Work Phone:		Work Phone:	
Email:		Email:	

Family: Please list all persons living in the household(s) with the child. Please provide ages of other children in the home:

Name	Nickname	Relationship	Gender	Age

COLLABORATION INFORMATION:

Pediatrician's Name:	Pediatrician's Phone #:
School Name and Address:	
Teacher Name:	Teacher Email:
Speech Language Pathologist Name:	Speech Language Pathologist Email:
Hearing Itinerant Name:	Hearing Itinerant Email:
Audiologist Name:	Audiologist Email:
Name/Role of Other Members of the Team:	Other Members Email:

*If accessing the sliding scale, please attach most recent tax return to this intake packet so that we can determine your rate. Sign below to acknowledge receipt and agreement with the therapy tuition billing policy.

Signature:	Signature:

I/we plan to: ☐ Enroll in Tuition Express ☐ Make monthly payments by check

Office Use Only: Assigned Rate per Session_____

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

Google Drive Permission Form

Dear CAOS Parents,

During the COVID school closure, CAOS staff created the CAOS Google Drive to be an online location where parents and staff could collaborate, share materials and updates with one another. Each parent was asked to give permission for the creation of a folder for their child. Once permission was granted, access to that folder was shared with the child's team (i.e., parents, deaf educator, and therapists). Each member of the team could read information, add their own updates and provide input into goal selection. In the past, we have used a folder on Carle's shared drive which can be accessed by all staff members while logged into their Carle computer. The Google drive allows us to extend access to families as well.

We found that this worked really well and we are interested in continuing it during the coming school year. Please read and sign below to grant permission for us to create a Google folder for your child. If you choose to opt out of the CAOS Google drive, you will still receive monthly newsletter updates and can provide input via email or phone calls. If you have questions, please contact Danielle.

Thank you for your time and collaboration!

CAOS Staff

Child's Name:

I understand that a folder for my child will be created and added to the CAOS Google drive, that the CAOS Google drive will contain information about my child's test scores, monthly targets and progress toward achieving those targets, and that my child's team will be invited to read and edit the documents in my child's folder. Further, I understand that the Google drive is outside Carle's encrypted network, but is protected by Google's security measures and each user needs to be invited to collaborate by CAOS staff.

Please carefully read the statements below, mark that statement that represents your decision about the CAOS Google drive for the coming school year.

Yes, I grant permission for CAOS staff to create a folder for my child on the CAOS Google drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

No, I do **not** grant permission for CAOS staff to create a folder for my child on the CAOS Google drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

ROI

Patient Name:_____ Date of Birth:_____

Other Names:_____ Last 4 digits of SSN:_____ MRN:_____

I authorize: The Carle Foundation* -Health Information Management
3310 Fields South Drive, Champaign, IL 61822
**Includes Carle Physician Group and Carle Hoopeston Regional Health Center*

☐ To Send to: _____
(Name of Health Care Facility, Physician, Individual, or Agency, etc.)

OR

☐ To Request from: _____
(Address)

_____ _____ _____
(City, State, Zip) (Phone) (Fax)

Method of Release: ☐ Mail ☐ Pick up at HIM Department (217) 902-6500 ☐ MyCarle Account (Available for 30 days)

SPECIFIC RECORDS TO BE RELEASED: *If no dates are indicated, only records created prior to or on the date of signature will be released.*

HOSPITALIZATION Dates:_____ to _____		CLINIC/OTHER	Dates:_____ to _____
☐ Inpatient Hospitalization ☐ Abstract ☐ Complete Stay ☐ History and Physical ☐ Consult(s) ☐ Progress Note(s) ☐ Operative Report(s) ☐ Discharge Summary ☐ Cardiology ☐ Reports ☐ Images	☐ Immunization Record ☐ Laboratory Report(s) ☐ Pathology ☐ Report(s) ☐ Slides ☐ Radiology (X-ray) ☐ Reports ☐ Images ☐ Therapy Services ☐ Other_____ ☐ Billing Records	☐ Cardiology ☐ Reports ☐ Images ☐ Immunization Record ☐ Laboratory Report(s) ☐ Pathology ☐ Report(s) ☐ Slides ☐ Radiology (X-ray) ☐ Reports ☐ Images	☐ Office Visits (Specify Provider) _____ _____ ☐ Emergency Department Visit(s) ☐ Home Care/Hospice ☐ One-Day Surgery ☐ Therapy Services ☐ Other _____ ☐ Billing Records

- The purpose of this disclosure of information is_____.
(i.e., continuing care, insurance claim, legal counsel, etc.)
- I understand that my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), treatment for alcohol and/or substance abuse, and genetic testing results. A separate special authorization must be completed to release mental health records.
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)
- I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.
- This authorization will expire on the following date or event_____. If I do not specify an expiration date or event, this authorization will expire on the date of the signature below and records will only be released for services up to and including that date.
- I understand that I am entitled to a copy of this authorization.
- I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

If the patient is 18 years of age or older, the patient must sign and date the form.

If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature:_____ Date Signed:_____

Printed Name of Person Signing (if not patient):_____ Phone#:_____

Mailing Address of Patient:_____ City:_____ State:_____ Zip:_____

STAFF USE ONLY *- Released by: Staff Initials_____ Type of ID Verified_____ Date:_____*

Child's Name: _____

Child's Date of Birth: _____

☐ Carle Foundation Hospital ECHO / CAOS
☐ Carle Physician Group _____
☐ Champaign Surgery Center _____
☐ Danville Surgery Center _____
☐ Carle Hoopeston Regional Health Center _____
☐ Carle Richland Memorial Hospital _____
☐ Carle BroMenn Medical Center _____
☐ Carle Eureka Hospital _____

INFORMED CONSENT FOR TELEHEALTH CONSULTATION - ECHO/CAOS

CONSENT

UNDERSTANDING AND ACKNOWLEDGMENT

A telehealth consultation has been recommended as a way to facilitate my care. Telehealth allows my condition to be assessed by a specialist who is not in my community. In order to perform the telehealth consultation, the specialist will review information about my condition. My healthcare provider will decide what information will be provided. The information will be transmitted electronically. Electronic transmission of information is like an e-mail but takes place using protected and dedicated communication lines. Information to be transmitted may include patient reports, laboratory results, radiograph reports, and photographs. In some situations, my healthcare provider will receive the specialist's report and will be able to review the recommendations with me.

By signing this agreement, I authorize the electronic transmission of my medical information to and/or a telehealth session with ECHO / CAOS staff *(name of healthcare provider completing telehealth consultation)* **and other persons involved in my medical treatment and care.** I understand the specialist providing the telehealth consultation and other persons involved in this telehealth consultation will have access to this information if applicable. I have been advised that the likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small. I understand that this agreement is not intended to describe actual treatment limitations and risks. This agreement is intended only to describe limitations and risks specific to the electronic transmission of information.

I understand that I can withdraw my permission to participate in a telehealth consultation at any time. Although I may choose not to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons, doing so may impair the specialist's ability to understand and address fully my healthcare issue(s). I understand that if I choose not to participate in the telehealth consultation, no action will be taken against me. I am always at liberty to pursue a face-to-face consultation.

I understand telehealth does have limitations. For example, the specialist is not able to palpate (directly examine with one's hands) but may use small special cameras to view close up details during a physical exam. My healthcare provider will address any other questions that I may have about the limitations of telehealth applicable to my specific condition.

I understand that if applicable, medical records of telehealth services will be kept at both the referring site and the consulting site. If I want to obtain copies of my records, I understand that I must contact the appropriate site's medical record office.

I understand that some or all of my medical information may be used for teaching or educational purposes at Carle.

I also agree to have my telehealth medical records reviewed for the purposes of evaluation (data collection, analysis, quality assurance and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. DECLINE _____ *(initials of patient only if declining)*

My healthcare provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I have read and agree to a telehealth consultation.

CONSENT FOR TREATMENT

Signature of Patient or Authorized Person	*Date*	*Time*
Signature of Witness	*Date*	*Time*

INTERPRETER SERVICES

I have provided interpretation in _____ *(type of language)* of any verbal and/or written information, including this consent form, that have been provided to the patient/authorized person to consent.

Interpreter Name (print full name)	*Badge #*	*Date*	*Time*
Signature (or if remote source, indicate company used)			

Carle

CAOS Outreach Individual Session Scheduling Tool

Thank you for your interest in working with the ECHO Program and Carle Auditory Oral School (CAOS)! Please complete the form below to help us to schedule your weekly services.

Child's Name: _____ Date of Birth: _____

How many sessions per week are you interested in scheduling? _____

I am interested in: ☐ ON-SITE SESSION ☐ TELE-SESSION ☐ COMBINATION OF ON-SITE & TELE

I am interested in support for:
☐ Speech (how my child produces sounds in words and sentences)
☐ Language (how my child puts words together and understands what they hear)
☐ Listening (how my child is hearing through their hearing aid/ BAHA/ cochlear implant)
☐ Auditory Processing (how my child processes information they are hearing)
☐ Literacy (how my child is preparing or learning to read, or how they are applying reading skills)
☐ Academic Support (helping my child with difficulties in academic subjects - reading, math, science, social studies, English, etc.)

In general, speech, language and listening therapy sessions will be billed to your insurance. If your child is accessing multiple sessions each week, or accesses literacy or academic support, outreach tuition will be billed. We determine the tuition rate based on the family's income and family size to ensure that the rate is manageable for each family. If applicable, please submit page 1 of your most recent federal tax return if we need to calculate your outreach tuition rate. Social security numbers can be blacked out/redacted.

Help us understand the times that your child would be available.
- Put a 1 in each time slot during the week that would be ideal for your child's session.
- Put a 2 in each time slot during the week that could work for your child's session.
- Put a 3 in each time slot during the week that would NOT be possible for your child's session.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00					
9:00					
10:00					
11:00					
12:00					
1:00					
2:00					
3:00					
4:00					

The best way to contact me to complete the scheduling process is: ☐ text ☐ email ☐ phone call
Contact information: _____

We like to plan 5 business days for the therapist to review records and plan for the first session, so once a session day and time are selected, sessions can start as soon as the following week. What is the earliest date you would like to begin sessions? _____
date

Thank you for taking the time to complete this form! We will be in touch soon!

Phone: (217) 326-2824 Email: Danielle.Chalfant@carle.com Cell Phone: (217) 722-6664

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