



MARIAN HOPE CENTER

FOR CHILDREN'S THERAPY

14820 E. 42nd Street, Independence, MO 64055 • p 816.695.1255 • f 816.478.7762

PRIOR TO YOUR CHILD ATTENDING THE MARIAN HOPE CENTER, ALL COMPLETED FORMS MUST BE RETURNED.

MARIAN HOPE CENTER ENROLLMENT FORM

If your child is a returning client with no changes from previous enrollment period, it is only necessary to complete the box below and all of pages 2-5.

Group (day & time): _____	
Child's Name: _____	Birth date: _____
Date of Enrollment: _____	Enrollment Period: <input type="checkbox"/> Fall/Spring <input type="checkbox"/> Summer

Parent's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

Work Phone (Mother): _____ Work Phone (Father): _____

Cell Phone (Mother): _____ Cell Phone (Father): _____

Emergency Contact (other than parents):

_____	_____	_____
(Name)	(Relationship)	(Phone)

Others allowed to pick up your child: from group: _____

Child's Physician: _____ Phone: _____

Physician's Address: _____

Diagnosis: _____

Special Precautions/Allergies/Medicines: _____

Concerns to be addressed: _____

Child's Name: _____ Birth date: _____

Enrollment Fee for 2010-2011 Session (August 23 - May 27)

The enrollment fee covers cost of materials, snacks, supplies, etc. for the Marian Hope Center. It does not include the cost of therapy and cannot be billed to insurance companies, Medicaid, First Steps, or the KCRC Autism Project. It must be paid by the families. In order to reserve your child's place in one of our therapy classes, **please pay the enrollment fee no later than August 16, 2010.** If you have questions, please contact Heather Ruoff at 816-695-1255.

- 3-hour class enrollment fee = \$250
- 2-hour class enrollment fee = \$150
- 1-hour group enrollment fee = \$100

Please select how you would like to pay the enrollment fee:

- Cash Check Credit Card (circle one): Visa Mastercard American Express Discover

Card #: _____ Exp. Date: _____

Therapy Costs for 2010-2011 Session (August 23 - May 27)

Thank you for choosing the Marian Hope Center as your therapy provider for your child. MHC offers integrated therapy to meet the needs of all children. We believe it is beneficial to children with special needs to socialize with peer models at an early age. Children attending our groups range from typical-developing to children with mild to severe disabilities. We are committed to providing quality services and implementing individually appropriate assessment and intervention plans. Please understand that payment of your bill is considered a part of your assessment and intervention.

If your child will be receiving therapy during a class (i.e., he or she is not enrolled as a peer model), please tell us your funding source for therapy. Please note that we accept straight Medicaid but are limited to the number of individual therapy openings during the class time. We are not a provider with any of the insurances that are associated with MC+ & cannot accept clients with this funding source. We are a Blue Cross Blue Shield (BCBS) provider. We will submit claims to BCBS for the individual therapy your child receives during classes. It is your responsibility to pay the member responsibility portion that BCBS does not cover under your plan (deductible, co-pay, co-insurance). If your insurance carrier is not BCBS, the MHC Business Manager will check on benefits and determine if it is feasible to bill your out-of-network insurance carrier.

- First Steps - Service Coordinator: _____
- KCRC/Autism Project - Service Coordinator: _____
- Insurance (copy of card is required)
- Medicaid (copy of card and a doctor's script is required)
- Private Pay
- Peer Model (my child will not receive direct therapy services during group)

Child's Name: _____ Birth date: _____

Please Initial By Session & Funding Source Applicable to Your Child

1. a) **3-hour therapeutic session with no individual therapy given is \$90.00/3-hr session***

- You will be billed for each month's preschool sessions the month prior to service. Payment is expected on or before the first session of that service month.
- In order to hold your spot, payment is expected whether your child is in attendance or not.

_____ Initials

b) **3-hour therapeutic session with individual OT &/or individual ST is \$120/hr/discipline**

- If you have insurance coverage for your child's diagnosis then insurance will be billed for individual therapy.
- If your child has a diagnosis for only one discipline then your insurance will be billed for individual therapy and you will be charged \$45.00/session for group time.
- You are responsible for all insurance deductibles, co-pays, and co-insurance.
- MHC works with our families to help with these charges & we offer payment plans.

_____ Initials

2. a) **2-hour therapeutic session with no individual therapy given is \$70.00/2-hr session***

- You will be billed for each month's preschool sessions the month prior to service. Payment is expected on or before the first session of that service month.
- In order to hold your spot, payment is expected whether your child is in attendance or not.

_____ Initials

b) **2-hour therapeutic session with individual OT &/or individual ST is \$120/hr/discipline**

- If you have insurance coverage for your child's diagnosis then insurance will be billed for individual therapy.
- If your child has a diagnosis for only one discipline then your insurance will be billed for individual therapy and you will be charged \$35.00/session for group time.
- You are responsible for all insurance deductibles, co-pays, and co-insurance.
- MHC works with our families to help with these charges & we offer payment plans.

_____ Initials

3. a) **1-hour therapeutic session with no individual therapy given is \$45.00/hour***

- You will be billed at the end of each month.
- Payment is expected upon receipt of invoice.

_____ Initials

b) **1-hour therapeutic session with individual therapy is \$120/hour.**

- If you have insurance coverage for your child's diagnosis then insurance will be billed for individual therapy.
- You are responsible for all insurance deductibles, co-pays, and co-insurance.
- MHC works with our families to help with these charges & we offer payment plans.

_____ Initials

(Continued on page 4)

Child's Name: _____ Birth date: _____

4. **All groups with First Steps & KCRO funding are contracted out to Outreach Therapies & Consulting, Inc.**
The amount billed to funding source is dependent on the number of therapist and children in attendance.

_____ **Initials**

5. **Evaluations and Reports**

Assessments include the evaluation and report writing at an hourly rate of \$120.00/hour - minimum time for an evaluation & report is 2 hours. We offer uninsured clients an adjustment of \$50.00/hr.

_____ **Initials**

***An increase to private pay rates was approved by the MHC Board of Directors in July, 2010. Please note that these rates will increase again by \$5 in the fall of 2011.**

Cancellations

PLEASE NOTE: Marian Hope Center requires 24 hour notice if a child will not be attending a class. A therapist in the class may be contacted by phone or email OR Heather Ruoff may be contacted at 816-695-1255 or heather@marianhopecenter.org. If your child is absent from a class and 24 hour notification has NOT been received a \$40 charge will be billed to the parents/caregivers for the missed session, regardless of payment source (KCRC, insurance, etc.).

In the event that it is necessary for the Marian Hope Center to cancel a therapy class, families will be notified via email and it will be posted on the Marian Hope Center website. In case of inclement weather, the Marian Hope Center will also be listed under school closings on KCTV-5.

My signature verifies that I have reviewed and understand the cancellation policy.

Parent Signature: _____

Fundraising Responsibility

As a non-profit organization, the Marian Hope Center relies heavily on fundraising to maintain the highest quality of services in a safe and comfortable atmosphere. We expect your family to support our organization in any manner available to you. We schedule four major annual fundraisers in addition to smaller events. Donations to the Marian Hope Center are tax-deductible. Please let us know what type of support we can expect from your family this year:

- Donation of needed items to the Marian Hope Center
- Volunteer time at the Marian Hope Center
- Monetary donation to the Marian Hope Center in the amount of \$_____

Please note the other major fundraising events that we are planning within the next year. Please check any of the following that you would like to participate in or volunteer for:

- Golf Tournament - July & September
- Texas Hold 'Em Poker Tournament - October
- Shopping Event - April

We appreciate your assistance and commitment to the Marian Hope Center. Our organization would not be able to realize our mission without the support of our families. A staff member from the Marian Hope Center will contact you regarding your fundraising responsibility.

Name: _____

Please contact me via Phone: _____
 Email: _____