READ & KEEP

(THE SIGNATURE PAGES HAVE BEEN EXTRACTED AND ARE INCLUDED IN YOUR ACTION PAGES PACKET)

- HIPAA HANDOUT
- FRAUD INSERVICE
- INCIDENT PROTOCOLS
- SCIP PROTOCOLS
- CODE OF CONDUCT
- CONTRACT

CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

Revised January 21, 2016

Introduction

The Code of Conduct, as set forth in the Code of Conduct itself, sets forth a framework intended to assist impacted employees to help people with special needs “live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm,” in addition to the specific guidance provided by the agency’s policies and training.

Similarly, the Notice to Mandated Reporters contains guidance designed to assist mandated reporters, and is intended to provide a summary of reporting obligations for mandated reporters. It is not intended to supplement or in any way add to the reporting obligations provided by law, rule, or regulation.

As provided by law, rule, or regulation, only custodians who have or will have regular and direct contact with vulnerable persons receiving services or support from facilities or providers covered by the *Justice Center Act* must sign that they have read and understand the Code of Conduct.

The framework provides:

1. **Person-Centered Approach**

   My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where consistent with agency policy, their right to assume risk in a safe manner, and recognizing each person’s potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever consistent with agency policy, I will work to support the individual’s preferences and interests.

2. **Physical, Emotional and Personal Well-being**

   I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm to others and themselves.

3. **Respect, Dignity and Choice**

   I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and consistent with agency policy. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and consistent with agency policy.

4. **Self-Determination**

    I will help people receiving supports and services realize their rights and responsibilities, and, as consistent with agency policy, make informed decisions and understand their options related to their physical health and emotional well-being.

5. **Relationships**

    I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and consistent with agency policy.

6. **Advocacy**

    I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as consistent with agency policy. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. **Personal Health Information and Confidentiality**

    I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law, rule, or regulation.

8. **Non-Discrimination**

    I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition or disability.

9. **Integrity, Responsibility and Professional Competency**

    I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. **Reporting Requirement**

    As a mandated reporter, I acknowledge my legal obligation under *Social Services Law* § 491, as may be amended from time to time or superseded, to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

____

PLEDGE TO ABIDE BY THE CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

I pledge to prevent abuse, neglect, or harm toward any person with special needs. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance and then notify emergency personnel, including 9-1-1 where appropriate, and inform the management of this organization. I pledge also to report the incident to the Justice Center for the Protection of People with Special Needs.

I acknowledge that I have read and that I understand the Code of Conduct.

I agree to abide by this Code of Conduct.

______________________	________________	___________
Signature	Print Name	Date

Program: IPSIDD AND INDEPENDENT CLINIC SERVICES

Department: LONG TERM OUTPATIENT REHAB

Facility/Provider Organization: CARING SLP, PSYCHOLOGY, OT & NUTRITION SERVICES, PLLC

REPORTABLE INCIDENTS, SERIOUS REPORTABLE INCIDENTS, ABUSE: PROTOCOLS

I. AUTHORITY

- Part 624 NYCRR
- Filed March 1, 2017
- Effective March 1, 2017

II. APPLICABILITY

- Developmental Disabilities Service Office (DDSO), operating a developmental center or certified facility.
- Voluntary (not-for-profit) agency operating a certified facility
- Home and Community Based Waiver Services (HCBS) pursuant to Part 635-10.1(c) shall comply with Part 624

III. POLICIES AND PROCEDURES

- Pursuant to Part 624-5(a)(b)

Every DDSO and voluntary agency shall develop incident/abuse policies and procedures that are in conformance with this Part to insure:

(ii) identification of reporting responsibilities of employees, interns, volunteers, consultants, contractors

This may be done by providing a copy of the appropriate policies/procedures to those who need to know.

IV. RESPONSIBILITY

It is the responsibility and condition of employment with Therapy Resources that all staff and contractors are governed by Part 624 as expressed in the policy statement on incidents issued by Administrative Director of Caring SLP, Psychology, OT & NT Services, PLLC.

V. CATEGORIES

A. REPORTABLE INCIDENT

Injury: any suspected or confirmed harm, hurt, or damage, caused by an act of that person or another, which results in a person requiring medical or dental treatment

B. SERIOUS REPORTABLE INCIDENT

Any injury which results in the admission of a person to a hospital or 24-hour infirmary for treatment or observation because of injury

C. MISSING PERSON

The unexpected and unauthorized absence of a person.

D. ABUSE

The maltreatment or mishandling of a person, the failure to intercede on behalf of a person receiving services.

Physical Abuse: physical contact which injury and or discomfort.

Sexual Abuse: any sexual contact is prohibited.

Psychological Abuse: verbal or non-verbal expression that subjects a person to ridicule and humiliation.

Seclusion: the placement of a person in a secured room from which he/she cannot leave at will.

E. DEATH

All loss of life regardless of cause

F. RESTRAINT

The act of limiting or controlling a person's behavior

G. MEDICAL ERROR

The administration of medication in an incorrect dosage, to the wrong person, and failure to administer prescribed medication.

H. POSSIBLE CRIMINAL ACTS

Action by person receiving services which are or appear to be a crime.

I. SENSITIVE SITUATION
Those sensitive situations which are reported to the administration to ensure awareness of the circumstances.

J. UNAUTHORIZED OR INAPPROPRIATE USE OF RESTRAINTS
The use of mechanical restraining devices to control a person without the written and prior authorization of a physician.

K. UNAUTHORIZED OR INAPPROPRIATE USE AVERSIVE CONDITIONING
The use of the technique for convenience as a substitute for programming, or for disciplinary (punishment) purposes.

L. VIOLATION OF A PERSON'S CIVIL RIGHTS
Any action or inaction which deprives a person the ability to exercise his/her legal rights.

M. MISTREATMENT
Failure to follow accepted treatment practices and standards in the field of developmental disabilities.

N. NEGLECT
Failure to provide appropriate services, treatment, or care by gross error in judgment.

VI. GENERAL REPORTING REQUIREMENTS

Type of Incident	Reported	Written Report	Form
1.Reportable Incident	within 48 hours	in certain circumstances	
2. Serious Reportable Incident	Immediately; but no later than 24 hours	Always; within 24 hours	OMR 147(1)
3. Allegation of Abuse	immediately	Always; within 24 hours to DDSO; within 72 hours to COC; within 3 working days to MHLS	OMR 147(A)

VI. INCIDENT REPORTING PROCEDURE

The purpose of the procedures are to ensure that incidents are reported in a timely manner and that proper notification is given.

In your capacity as a clinician you are governed by reporting requirements of Part 624 which requires timely reporting and notification, without exception.

A. Each clinician must immediately notify their supervisor of every incident involving individuals with developmental disabilities that they have knowledge of.

B. If it is determined the that the incident is ***reportable***

- telephone, fax, or email notification must be made within 24 hours to

  Resident Manager, Supervisor, or designee of the certified facility

  Administrative Director or designee of Caring Therapy Services

- A written report (Incident Report Form) must be submitted within **48 hours** by the person reporting the incident

C. If it is determined that the incident is a ***serious reportable***

- Immediate telephone, fax or email notification must be made to

  Resident Manager, Supervisor, or designee of the certified facility who will notify DDSO within 24 hours and initiate an investigation

  Prepare and submit a written preliminary report within **24 hours to Administrative Director or designee** of Caring Therapy Services

D. If it is determined that the incident is a allegation of abuse

1. Immediately telephone, fax or email notification must be made to

   Resident Manager, Supervisor, or designee of the certified facility

   Administrative Director or designee of Caring Therapy Services

2. Written notification by close of business to

   Resident Manager, Supervisor, or designee of the certified facility

   Administrative Director or designee of Caring Therapy Services
   who will request a written report from the clinician within **24 hours**

3. Written preliminary report **within 24 hours to**

   Resident Manager, Supervisor, or designee of the certified facility will send a written report to DDSO within 24 hours; send

written report to COC within 72 hours and MHLS and Board of Visitors as applicable

<u>Administrative Director or designee</u> of Caring Therapy Services who in turn shall inform the CEO or Designee of the certified facility of the existence of the internal report

**it is important to note that each facility has their own internal incident reporting and investigatory protocols which should be considered in the event that any procedural questions arise.*

____

Administrative Director

____

Date

Internal Incident Review Process

Covered Employees/Contractors

All employees/contractors are mandated to report and notify appropriate parties when they become aware/observe any action/activity which constitute and incident or allegation of abuse.

Failure to Report

Failure to report an incident or allegation of abuse in a timely manner as set forth in the official incident and allegation of abuse protocols, may result in disciplinary action in accordance with personnel manual.

INVESTIGATION

In most cases incidents and allegations of abuse will be investigated by the contract agency. This process may include the investigation of witnesses and the interrogation of witnesses and suspects.

In the event that an employee/contractor of Caring Therapy Services is the target/suspect of an investigation or interrogation, CTS reserves the right to:

- Require employee/contractor to provide additional information (written if required) with utmost dispatch.
- Conduct an independent inquiry to gather clarifying information.
- Suspend employee/contractor for a period of time up to 72 hours.
- Initiate disciplinary actions against employee/contractor in accordance with personnel policies.

INCIDENT REPORT for AN ALLEGATION OF ABUSE

BACKGROUND INFORMATION:
Person Reporting: ____________________________________

Name of Individual: _____________________________________
Date: _______ / ________ / _______

Agency: _________________________ Work Location: ___________________________

Date of Incident: ___ / ___ / ___ Time: ___ a.m./p.m.
Reported by: Telephone: ( )________________ Fax: ( )_____________________
Email:_______________________

Involved Persons: Agency TRC

______________________ ______________________

______________________ ______________________

Category of Reportable Incident: ☐ Reportable ☐ Serious Reportable ☐ Allegation of Abuse

DESCRIPTION OF INCIDENT (Clearly state the facts and your observations. Continue on the reverse side if necessary)

____
____
____
____
____
____
____
____
____
____

Did the individual receive medical attention? ☐ Yes ☐ No
Was the individual referred to hospital? ☐ Yes ☐ No
Were the police notified? ☐ Yes ☐ No

NOTIFICATION

Agency person notified ___________________________ Date: _____________
CTS person notified ___________________________ Date: _____________
Other person notified ___________________________ Date: _____________

Signature of person
reporting____________________________________Date_______________________

DATE RECEIVED AT CARING THERAPY SERVICES:
____

Director/ Designee ____Initials:
____

Proper notification? ☐ Yes ☐ No Timely notification? ☐ Yes ☐ No

Disposition: ☐ Accepted *-no further action required unless agency deems otherwise*
☐ Rejected *-additional information required*

Request additional information? ☐ Yes ☐ No Contact Made? ☐ Yes ☐ No
Date:___ /___ / ___

Comments:
____
____
____
____
____
____
____

30-Day Review: ☐ Open ☐ Closed 90-Day Review: ☐ Open ☐ Closed

Status:

☐ Unknown Origin ☐ Confirmed ☐ Disconfirmed ☐ Substantiated ☐ Unsubstantiated
Date: ________ Date: ______ Date: ______ Date: ______ Date: _________

When Charges are Preferred

If charges are preferred against an employee/contractor of Caring Therapy Services the following will ensue:

- The Director/Designee must be notified in writing.
- The Director/Designee will designate an administrator to serve notice upon employee/contractor informing him/her of their rights, decide if and immediate suspension is warranted to protect the individuals served.

Note: Whenever charges are preferred against an employee/contractor, Caring Therapy Services will provide an impartial representative to advise him/her of their rights.

Internal Routing Process

All incident related correspondence must be brought to the attention of the Director or designee.

If the initial incident is reported in a timely manner and accepted by the Director/Designee no further action will be required, unless the contract agency deems otherwise. If it determined that the report was to be rejected and additional information is required the Director will refer the matter to an internal administrator,

The internal administrator will launch an inquiry and report finding recommendation, and corrective action to Director.

If charges are preferred against an employee/contractor the internal administrator will assign an impartial representative, prior to launching an investigation/interrogation and report findings, recommendations, and corrective action in writing and strict confidence to Director before final disposition is made.

Review of Process

1. Notify Resident Manager or Supervisor of incident.
2. Notify CTS Office of the incident.
3. Submit your written report to Agency and Caring Therapy Services within 24 hours.
4. Where there have been allegations of abuse and/or the reporting of certain sensitive situations, Caring Therapy Services reserves the right to temporarily remove the clinician until inquiries are completed and written reports are provided. Upon receipt of all final information, clinician will be given written notification of approval or disapproval to return to work site.

**Sign and return this page.
Keep pages 1-10 for your records and reference.

I have reviewed and understand the procedures as outlined above regarding: **REPORTABLE INCIDENTS, SERIOUS REPORTABLE INCIDENTS, ABUSE: PROTOCOLS**

Name of Clinician: ______________________________________

Title:____

License #: ____

Signature: ____

Date Signed: ____

Updated March, 2017

CTS HIPAA Compliance Information Sheet

WHAT IS HIPAA?
HIPAA means **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct or The Privacy Law. In the United Stated, this is being overseen by the OCR (Office of Civil Rights).

WHAT IS PHI?
PHI means **P**rotected **H**ealth **I**nformation. If the consumer's full name, or other readily identifiable factors appear on a piece of health related document, this is PHI. Written or verbal discussions are to be HIPAA compliant.

WHAT IS TPO?
TPO means **T**reatment, **P**ayment and **O**perations. These are the necessary day to day functions needed to efficiently treat consumers at the assigned locations. Such functions include phone calls, faxes, verbal discussions, copying, mailing, emailing, transporting, filing, discarding, storing and computerizing the PHI.

HOW DO CTSs THERAPISTS **BECOME** HIPAA COMPLIANT?
This is done upon being hired as an CTS therapist. We have existing Business Associate Agreements and HIPAA contracts in place with the agencies and the carriers. Through CTS, each therapist has a HIPAA compliant relationship with the consumers upon being assigned a caseload at each site.

HOW DO CTSs THERAPISTS **REMAIN** HIPAA COMPLIANT?

- Keep all progress notes, evaluations, treatment plans, doctor's orders in the site binder at the designated confidential location at the site. Do not remove the binder from the site for any reason whatsoever.

- When transporting your monthly paperwork to be copied (if no copier at site), to the post office, or for completion of treatment plans at home, always keep the PHI in the locked trunk of your vehicle with the Authorization to Transport form as the coversheet. [[Keep in mind that daily notes are to be done daily, at the site. Complete your daily notes after your treatment session is over, or while discussing your data face-to-face with your consumers during the treatment session.]]

- Mail your bi-monthly and monthly paperwork in to the CTS office. Once the stamp is on your envelope, the enclosed PHI is federally protected.

- If you prefer to personally bring your completed bi-monthly and monthly paperwork in to the CTS office, transport it in the locked trunk of your vehicle with the Authorization to Transport form as the coversheet.

- Only process and store computerized notes, plans and evaluations on a confidential computer with firewall and password protection. No one else is to be able to access the PHI on your computer.

- If it is absolutely necessary to complete PHI notes or plans at home (handwritten or computerized) do so in the strictest, most confidential setting. No one else living/visiting your home is to have access to this PHI. Do not leave the PHI exposed to view by anyone else living/visiting your home. These notes are then to be kept in a locked file drawer or locked container when you are done handling them.

- Verbal references must not include complete personal identifiers of the consumer. Use either first or last name or initials. Discussions are to be conducted in lowered tones, out of earshot of others not involved in the immediate clinical care of the consumer. This is in keeping with the "minimum necessary contact" rule.

- **Shred/ or rip into unrecognizable pieces** all PHI documents to be discarded. You cannot discard PHI with recognizable personal identifiers on it. If you may find it necessary to use the back of a piece of PHI document with personal identifiers on the front, then it has to be treated in the HIPAA compliant manner already outlined.

- When faxing PHI, you must use a coversheet with confidential disclaimer footer. If not, then you must call the intended recipient, fax the PHI without the confidential coversheet and then call the recipient again to ensure a completed fax transaction.

- Emails with PHI must always include a confidential disclaimer footer. (Feel free to copy and edit the CTS confidential footer.) If the PHI communication is initiated from the CTS office, then no need to add your footer. If you are initiating the communication, use a confidential footer. Many therapists simply copy and hit reply to one of the old CTS messages, change the subject heading, but maintain the original confidential footer. This is acceptable.

WHEN DOES THE HIPAA COMPLIANT RELATIONSHIP END?

- When your assignment at a site ends, ALL the PHI relative to that site must either be left on-site in the confidential site binder or mailed back to CTS. Do not keep any of this PHI in your home or in your car or in your office or on your computer. Return or completely shred ALL the hard copies of the PHI. Delete all electronic PHI for this site from your computer.

- Your assignment has ended, and you are not protected by any extended Business Associate agreements then. Your HIPAA relationship has ended with the consumer(s) at this site. If found in violation of this relationship that has ended, you will be exposed to legal liabilities because of possession of the PHI of the consumer(s) at this site. Your further use/or possession of this PHI is in violation of the HIPAA law.

Caring Therapy Services, PLLC

17 North Plank Road, Suite 10, Newburgh, NY 12550. Phone: 845-800-9305. Fax: 844-800-1470

Authorization to transport PHI between CTS offices and from sites.

- ☐ Bi-monthly/Monthly PHI (copies already on site/to be made for site binder)
- ☐ Bi-monthly/Monthly PHI (being taken to post office to be mailed to CTS office)
- ☐ Bi-monthly/Monthly PHI (for computerized or hand-written completion off-site)
- ☐ Bi-monthly/Monthly PHI (for temporary maintenance in locked, confidential file drawer/container off-site)
- ☐ ____

I hereby declare that this transfer of PHI between CTS offices/off-site locations is without malicious intent. Every reasonable effort has been made to secure the privacy of the enclosed PHI. The transport is for auditing, billing, filing or other processing necessary and consistent with TPO regulations under HIPAA rules.

Signature:____

Title:____

Date:____

Please return pages 4 and 5. Keep pages 1-3 for your records, reference and use.

PROTECTED HEALTH INFORMATION RELEASE
Therapist's Blanket Release.

NAME OF THERAPIST:		
Signature of Therapist:		
Nature of request:	Current PPD to be faxed to Residence Manager at assigned sites	
	Current PPD to be faxed to Article 16 Clinic or referring Hospital	
Requested by:	Residence Manager at assigned sites or Article 16 Clinic	
Request approved by:	Yvonne Pasqualicchio	Title: Privacy Officer
Signature:		
DATE:		

Confidentiality notice: By my signature I hereby agree to the release of protected health information only to the parties listed above. Carring Therapy Services will not be held responsible for re-disclosure of said information.

Please return pages 4 and 5. Keep pages 1-3 for your records, reference and use.

I have read and fully understand the contents of the information contained in **CTS HIPAA Compliance Overview**

Date : ______________________________________

Name: ____

Title: ____

Signature: ____________________________________

License #: _____________________________________

Caring Therapy Services, PLLC

Policy and Procedures relative to SCIP (Strategies for Crisis Intervention Prevention)

As outside employees, it is not recommended that our therapists do crisis intervention within the residences.

The residential agency is responsible for ensuring that its employees are fully SCIP trained.

As part of the initial background gathering and evaluation, the question of behaviors should be addressed.

The residential agency should have a defined Behavior Plan for the individual with problematic behaviors.

The clinician should be aware of and trained in the implementation of the Behavior Plan for the purpose of providing therapy in the best possible learning environment.

If the consumer has a history of behaviors that are of concern to the clinician OR out of the realm of his ability to properly control, **the therapy must be conducted in the presence of a SCIP trained residential agency employee.**

If the clinician determines that the behaviors prevent the implementation of or the benefits of clinical treatment, the appropriate recommendation to discontinue therapy should be made.

Sign and return this page.
Keep page 1 for your records and reference.

Policy and Procedures relative to SCIP (Strategies for Crisis Intervention Prevention)

I have reviewed and understand the procedures as outlined above.

Name of Clinician: ____

Title:____

Signature: ____

License #: ____

Date Signed: ____

Electronic Inservice
Presented by Caring Therapy Services
Topic: What is Fraud?

TO: All Therapists
DATE: [doh]

Instructions: Please read and review this information very carefully. Upon completion, please sign the final page to indicate your review and understanding of the information contained in this inservice.

Please send the verification page with your original signature with your next invoice and paperwork. The signed verification page will be required in order to process your next paycheck.

Dear CTS Therapists:

What is Fraud?

1. Not indicating your true arrival and departure time at the site is perceived as fraud. Example: 3pm-5:00pm at your first site, then 5:00pm to 7:00pm at your second site which is 10 minutes away. Although we are taught not to be "clock-watchers", it is very important that you record your time correctly. It prevents the perception of any "mis-representation" of your treatment.

2. Mailing in your end-of month attendance sheet with different information than what was faxed in at the middle of the month. Example: Faxed in that Jim absent, Pat present for the 10th. Mailed in that Jim present and Pat absent for the 10th.

3. Going to the site on one day, but deliberately filling out paperwork and having staff sign for another day. Example: You are scheduled for Tuesday/Thursday. You change days w/o alerting the CTS office. You make your visits on Mon/Wed, then carefully document your attendance for Tue/Th anyway.

4. You forgot to get staff signature, so, you do it yourself. Example: You went in on the wrong day, so you just sign staff member's name for your regularly scheduled days. Signing someone else's name on your Medicaid documentation is not only fraud, it is forgery. Both offenses carry severe penalties.

5. Billing for treatment sessions that did not occur.

6. Billing for sessions for consumers who were hospitalized, on vacation, or out for an extended period.

7. Billing a full session for a brief session . Example: The duration of a full session is thirty minutes or more. A brief session would be for 29 minutes or less. (Creating your session note is not part of the treatment time). Example: Treat Pamela for 22 minutes, dismiss Pamela, write up note for 8 minutes. This would be a brief session. What is permissible, is to record your data in front of the consumer and discuss what you are writing with consumer present.

All the above examples are fraudulent, and will result in penalties. Penalties range from and include revocation of your clinical license and mandatory refunding of all monies reimbursed to you for fraudulent visits and attorney's fees associated with ETS retrieving money it is owed.

For even the most conscientious therapists, mistakes happen, so:

WHAT IS THE DIFFERENCE BETWEEN A MISTAKE AND FRAUD?

1. It is against company policy to switch days without getting prior approval from CTS. This infraction creates an opportunity for non-payment for your services and/or termination. This type of situation often creates double-billing. Double-billing is a serious Medicaid issue.

If you go to your site, and you are asked to return on a different day (for whatever reason), our office must be notified immediately. It is our job to manage all schedule changes!

It is an error if you forget to get staff to sign before leaving the site. You correct it by calling CTS or the site immediately. Ask the manager or designee to pull your original attendance sheet, and sign off on the correct day. **Don't forget to get staff's signature**!

It is an error to switch days w/o telling the CTS office ahead of time. You correct it by calling or emailing immediately**. Don't forget to get approval from ETS to change your schedule!**

SUMMARY

~Mistakes happen. Report them immediately. Document your corrections.
~Fraud is unacceptable and punishable. If fraudulent activity is proven, it will result in loss of your clinical license with severe financial penalties imposed.

This information is not meant to threaten or intimidate in any way. It is certainly not meant to negatively reflect on any of the positive and professional things that you are doing. We believe that the vast majority of our therapists are providing their services in an exemplary manner. We appreciate your service!

However, we want all of you to be mindful of all of the professional and compliance requirements for which we are accountable. Please do not hesitate to call me immediately if you have questions or need any more clarification on anything.

Most Sincerely,
Yvonne Pasqualicchio
Administrative Director

[Sign off page follows]

Inservice: **What is Fraud**

****

Return this page for Inservice Attendance.
Keep pages 1-3 for your records and reference.

I have read and fully understand the contents of the information contained in the Inservice**: What is Fraud?**

Date Read: ____

Your Name: ____

Title: ____

Signature: ____

License #: ____

***** Please remember that this page with your original signature is required in order to process and approve your next paycheck.**

Thank You