Max★Ability
THERAPY SERVICES

Omaha
10909 Mill Valley Rd Ste 210
Omaha, NE 68154

Bellevue
1001 Fort Crook Rd N Ste 202
Bellevue, NE 68005

Phone: (402) 391-5002 Fax: (402) 343-1278
Email: therapy@maxability.org Website: maxability.org

CONSENT FORM

Regarding the Following Patient:
Name:_____ Phone: _____
Address: _____ Date of Birth: _____
City/State/Zip: _____

☐ I hereby authorize, MaxAbility Therapy Services, P.C. to evaluate and treat:
_____ (Patient Name)

☐ I hereby authorize, MaxAbility Therapy Services, P.C. to request information FROM and release TO: _____
(Individual or Organization Name)

Records to be Released could include any of the following:

Date(s) treatment was received: _____

☐ Consultation Report ☐ Entire Report ☐ History & Physical ☐ Evaluation
☐ Plan of Care ☐ Photographs, Videos, & Digital Images ☐ Other

☐ Script for Speech Therapy Evaluation and Treatment
☐ Script for Occupational Therapy Evaluation and Treatment
☐ Script for Physical Therapy Evaluation and Treatment

Purpose of Release could include any of the Following
☐ Coordination of Care ☐ Insurance ☐ Litigation ☐ Personal ☐ Other
☐ Training of Medical professionals/students

Statement of Authorization

- I understand that, except for research related treatment, MaxAbility Therapy Services, P.C. will not condition my treatment upon my signing this authorization
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to MaxAbility Therapy Services, P.C. A photocopy of this authorization will be treated in the same manner as the original
- I understand that once information is released as speciied in this authorization, the facility, their employees and MaxAbility Therapy Services, P.C., cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information
- I have received a copy of the Privacy Policy and Universal Precautions Policy

_____ _____
Signature of Patient/Legal Authorized Representative Date

_____ _____
Relationship to patient Reason patient is unable to sign

_____ _____
Signature of Witness Date

**********For Office Use Only**********

Medical Records Released By: _____ Date:_____
Medical Records Released By: _____ Date:_____
Medical Records Released By: _____ Date:_____
Medical Records Released By: _____ Date:_____

Method: ☐ Mailed ☐ Picked Up ☐ Faxed ☐ Emailed

Attendance/Cancellation Policy

Welcome to MaxAbility! We strive to provide our patients with the best therapy outcomes as possible. For the best opportunity to achieve this, 100% attendance of the frequency established in your child's plan of care is optimal. However, we do understand occasional changes are necessary due to illness, vacations, etc. Please review and initial the following policy statements regarding attendance and cancellations.

_____ Monthly attendance of 75% is required to maintain your weekly therapy time slot. If you fall below 75% and you are unable to correct the issue you will be removed from the schedule.

_____ If you need to cancel your appointment for any reason, please call the office at least 24 hours prior to the scheduled appointment in order for your session to be considered "excused". Same day cancellations will not be excused.

_____ Arriving late to your appointment will result in a shortened session. Two or more late arrivals may warrant a change in your scheduled therapy appointment time.

_____ If an appointment is not cancelled and the patient does not show up, it will be considered a 'no show' visit. Two consecutive 'no shows' will result in you being removed from the schedule.

_____ Please make all cancellations or schedule changes through the front office. Schedule changes made only with the therapists may not make it onto the schedule, resulting in a 'no show' visit

_____ We want you to be an active member of your child's therapy team. If you are bringing a child to their therapy appointment and choose not to stay with them, you are required to be back in the office 10 minutes prior to your child's appointment ending so the therapist can give you an update, provide education, and other appointments are kept on time. We also request that you stay on the premises during your child's appointment. There is a waiting area in the main part of the building

We are happy to work out attendance issues with you. Lease let us know if you are experiencing a problem with your current situation.

I hereby understand the above scheduling policy and agree to abide by it

_____ _____

Parent or legal guardian Date

Scheduling Policy

Welcome to MaxAbility! After your initial evaluation, your child's therapist will work with you to set a frequency of appointments based on your child's needs. We will work hard to find you a time slot that works for your family. For optimal patient care and best interest of your child and his/her outcomes, time slots are intended to be weekly unless otherwise recommended by your child's therapist. Please review and initial the following policy statements regarding scheduling.

_____ Once a frequency is determined and ongoing treatment for your child has been scheduled, this will be your therapy time slot moving forward. This time is reserved for your child for the duration of their plan of care as long as all other policies are being followed.

_____ If you are unable to maintain the determined frequency, and cannot schedule at the same time each week, you will need to call the office week by week to schedule; however, we cannot schedule these out more than 1 week in advance.

_____ If you need to put your therapy on hold for whatever reason, we can hold your therapy slot for up to 2 weeks at a time. If you need more time than this, you will be removed from the schedule until you are ready to resume services. However, we will not be able to guarantee your original time slot. If you would like to hold your spot for longer than 2 weeks, you can pay a private fee to hold your time slot. (Please note that this fee is not reimbursable by insurance.

Thank you for choosing MaxAbility for your therapy needs. We are happy to work out scheduling issues with you. Please let us know if you are experiencing a problem with your current situation.

I hereby understand the above scheduling policy and agree to abide by it.

_____ _____

Parent or legal guardian Date

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Financial Policy

Patient Name:
Date of Birth:

Welcome to our office! We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Please read carefully and Initial:

1: ____Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. Benefits are verified. Costs are estimated based upon your out of pocket obligation to your insurance company and recommended Plan of Care.

2: ____As a courtesy, MaxAbility Therapy Services establishes payment plans with all clients, due at the time of services. This procedure allows clients to understand and manage their financial obligation.

3: ____ Our fees are generally considered to fall within the usual, customary, and reasonable (UCR) range by most insurance carriers. Occasionally an insurance company reimburses based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area. MaxAbility does not accept arbitrary fee determinations for services a carrier considers not medically necessary. This office cannot accept responsibility for negotiating settlements on disputed claims. Not all services are covered benefits in all contracts.

4: ____ In the event insurance benefits are exhausted or client is private pay, client agrees to make full payment at the time of services.

5: ____ Your credit card information will be collected during your first visit. It will be kept on file until all charges/claims are paid. If you fail to pay any balance after 60 days of receipt, the charges will be applied to your credit card.

6: ____ Any returned check will be subject to a NSF fee of $25.00, due at the next visit.

7: ____ MaxAbility Therapy Services accepts cash, checks, and most major credit cards.

Plan of Care/Payment Plan

- Recommended frequency and duration of therapy_____
- Insurance Deductible _____ Co-Insurance_____
- Co-Pay _____ Estimated out of pocket responsibility _____
- Amount payable at each Visit_____

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact billing department promptly for assistance in management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

I hereby understand the above financial policy and agree to abide by it.

_____ _____

Patient or Responsible Party Date

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MaxAbility Credit Card Form

☐ VISA ☐ MASTERCARD	☐ DISCOVER ☐ AMERICAN EXP
CARD NUMBER	SECURITY CODE
BILLING ZIP CODE	EXPIRATION DATE
ACCOUNT #	CHILD'S NAME
NAME OF BANK	BANK PHONE #

I, _____ give permission for MaxAbility Therapy Services, P.C. to charge my card should I not pay a balance within 60 days of receiving a statement

Signature _____ Date_____

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Waiver and Release From Liability

By this Waiver, I assume any risk, and take full responsibility and waive any claims of personal injury death or damage to personal property associated with MaxAbility Therapy Services, P.C. Pediatric Services activities, and events organized by MaxAbility Therapy Services, P.C.

I understand and confirm that by signing this WAIVER AND RELEASE I have given up considerable future legal rights. I have signed this Agreement freely, voluntarily, under no duress. My signature is proof of my intention to execute a complete and unconditional WAIVER AND RELEASE of all liability to the full extent of the law. I am 18 years of age or older and mentally compentent to enter into this waiver.

Participants Printed Name: _____

Signature: _____ Date: _____

If Participant is under 18 years of age:

Participants Printed Name: _____

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

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CONSENT WAIVER AND RELEASE
Promotional Material

I, the undersigned, hereby give consent to MaxAbility Therapy Services, P.C. to use for demonstration and/or promotional purposes any material compiled before, during, or after my examination and therapy. This includes photographs, tapes, or audiovisual illustrations which may help to inform the public and/or promote the cause of specified therapies or devices. This also includes commentary by the patient or family which may be quoted to promote the company, its therapies or devices. I understand the subject material may appear in written publications (such as brochures), on radio or television, or on the company's website.

I further understand that MaxAbility Therapy Services, P.C. is a private corporation established to develop and market assistive living devices for persons with disability. In addition to the material covered above, I volunteer to be contacted by interested parties to share the success of my treatment.

I hereby waive my rights to privacy in connection with the consent given above, and I hereby release, discharge, and agree to hold harmless from any liability now or in the future to MaxAbility Therapy Services, P.C.

Client Name:_____ Signature:_____ Date: _____

Parent/Guardian: _____ Signature:_____ Date: _____

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Therapy Parent Questionnaire

Child's Name:_____ Birth date:_____
Parent/Guardian Name(s):_____
Physician:_____
Home Address:_____
Home phone:_____ Work:_____ Cell:_____
Email address:_____
Child lives with: _____
Primary language spoken in home: _____

Medical History
Birth weight:_____ [ ] Full Term Pregnancy [ ] Prematurity - Born at _____ weeks
Type of delivery:_____
Complications at birth for baby:[ ] cyanosis [ ] limpness [ ] stiffness [ ] congenital defect
[ ] feeding [ ] seizures [ ] ventilator [ ] other _____
If any above are checked, please provided additional information:
_____
_____

Please describe any important illnesses, injuries or surgeries:
_____
_____
_____
_____
Current medical diagnoses/conditions: (ADHD, Autism, LD, CP etc.): _____
_____
Current medications: _____
Allergies:_____
Dietary Restrictions:_____
History of ear infections or hearing loss:_____
Family history of communication problems: _____

Developmental Milestones

Approximate age at which your child did the following:

Raised head		Stood alone	
Rolled		Walked	
Sat alone			
Crawled on hands and knees			
Pulled to stand			

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Your general impression of your child's motor development:

	Advanced	Normal	Slow
Gross motor: (running, jumping, ball play)			
Fine motor: (manipulation of objects with hands)			
Handwriting/coloring skills			

At what **approximate age** did your child say their first word(s): _____

Your general impression of your child's speech-language development:

	Advanced	Normal	Slow
Speech			
Social Skills/play skills			
Getting wants and needs met and known			
Forming sentences			
Vocabulary			
Asking questions			
Following simple directions			
Following complex directions			

Concerns for Your Child

Please check all areas of concern:

Fine motor		Muscle tone		Sensory Processing	
Motor weakness		Endurance		Speech/articulation	
Feeding		Attention/ Distractibility		Following Directions	
Dressing		Play skills		Language	
Toileting/Restroom routine		Over/Under active		Oral Motor	
Handwriting		Over sensitive/Under responsive:			

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Please further describe the concerns that were checked: _____

What would you like us to help you and your child with? _____

What are your goals for your child? _____

What are your child's strengths? _____

Is your child currently receiving any therapy or involved in any special programs? _____

What other evaluations, therapy or special programs has your child had in the past and when? _____

Thank you for completing the form. We look forward to meeting you and your child.

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SICK CHILD POLICY

Please help us keep your children and our staff healthy. The sick season is here and we would like to reduce the spread of illness.

In order to maximize health and wellness, please note the following:

- **All kids, parents, and caregivers will use hand sanitizer prior to entering the gym or treatment rooms.**
- **Staff will use disinfectant wipes on tables/surfaces used, when a treatment session is over.**
- **Staff will remove germ exposed toys/items to cleaning area.**
- **The entire office/practice is cleaned every night.**

Children with the following should not attend therapy:

- **Severe Cold or any Flu symptoms**
- **Fever-above 100 degrees Fahrenheit**
- **Diarrhea-loose or runny stool in last 12 hours**
- **Vomiting-within the last 12 hours**
- **Rash-any rash, especially when accompanied by fever**

Common Illnesses-child should not attend therapy:

- **Croup or RSV**
- **Pink Eye/Conjunctivitis**
- **Chicken Pox *refer to Health Dept. guidelines for return to therapy**
- **Roseola**
- **Strep Infection**
- **Fifth's Disease**
- **Hand Foot and Mouth**
- **Impetigo**
- **Vaccine Preventable Diseases (ex. Whooping cough, measles, mumps)**

All sick kids will be required to stay at home until symptom free for a minimum of 24 hours. In certain cases, a doctor's prescription to return to therapy may be required.

When in doubt about your child's health, please call your Pediatrician for medical guidance. Regarding your child's attendance for therapy, please contact the office at 402-391-5002. Your cooperation with the policy is greatly appreciated.

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PRIVACY POLICY

As required by privacy regulations created as a result of the Health Insurance Portability/Accountability Act of 1986, **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.

Commitment to Privacy:

This clinic is committed to maintaining the privacy of your protected health information(PHI). We are required by law to maintain the confidentiality of your health information. We also are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in this clinic concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect.

We may use and Disclose Your Protected Health Information (PHI) in the Following Ways:

1. Treatment: This clinic may use your PHI for treatment purposes. We may disclose your PHI to other health care providers for purposes related to your treatment. This may include, but is not limited to, your doctor, other therapists, caseworker, and school related personnel.
2. Payment: This clinic may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs.
3. Health Care Operations: This clinic may use and disclose you PHI to operate our business. An example of this is, using your PHI to evaluate the quality of care you receive from us.
4. Appointment: This clinic may use and disclose your PHI to contact you and remind you of an appointment. An example of this is leaving a message on your answering machine.
5. Release of Information to Family/Friends: This clinic may release your PHI to a friend or family member that in involved in your care. For example, if a friend, babysitter, grandparent, or other family member brings you or your child to the clinic for care, they will receive medical information abour your or that child.
6. Disclosures Required by Law: This clinic will use and disclose your PHI when we are required to do so by federal, state and/or local law.

Uses and Disclosure of your PHI in Certain Special Circumstances:

1. Public Health Risks: This clinic may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of reporting child abuse or neglect, maintaining vital records, preventing or controlling disease, injury or disability, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting problems with products or devices, notifying individuals that a product or device they may be using has been recalled, or notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities: This clinic may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor governmental programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings: This clinic may use and disclose your PHI in response to a court order, if you are involved in a law suit or similar proceedings.
4. Law Enforcement: This clinic may release PHI if asked to do so by a law enforcement official regarding a crime victim. If we are unable to obtain the person's agreement, concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, or in an emergency, to report a crime.
5. Serious Threats to Health and Safety: This clinic may use and disclose your PHI when necessary to reduce or prevent a serious threat to you or your child's health and safety of the health and safety of another individual.
6. Military: This clinic may disclose your PHI in you are a member of US or foreign military forces and if required by the appropriate authorities.
7. National Security: This clinic may disclose you PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. Inmates: This clinic may disclose your PHI to correctional institutions or law enforcement officials in you or your child is an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care service to you or your child, for the safety and security of the institution and to protect your health and safety or the health and safety of other individuals.
9. Workers' Compensation: The clinic may release your PHI for workers' compensation and similar programs.

Your Rights Regarding Your PHI:

You have the following rights regarding your PHI that we maintain about you or your child. Request involving your rights must be submitted in writing.

1. Confidential Communications: You have the right to request that our clinic communicate with you about health related issues in a particular manner or at a certain location. The request must specify the method of contact or the location where you wish to be contacted. We will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure or your PHI to only certain individuals involved in your care or the payment for your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must describe in a clear and concise fashion the information you wish restricted, whether you are requesting to limit our clinic's use, disclosure or both and to whom you want the limits to apply.
3. Inspection and Copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you or your child, including patient medical records and billing records. This clinic may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.
4. Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by or for this clinic. You must provide us with a reason that supports your request for the amendment. Also, we may deny your request if you ask us to amend information that is in our opinion accurate and complete, not part of the PHI, not created by our clinic or that individual/entity that created the information is not available to amend the information.

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5. Accounting of Disclosure: All of our patients have the right to request an "accounting of disclosures" which is a list of certain non-routine disclosures our clinic has made of your PHI for non-treatments, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our clinic is not required to be documented. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 15, 2003.
6. Right to a Paper Copy of this Notice: You are entitled to receive a paper copy of this notice of privacy practices at any time. A written request is not required.
7. Right to File a Complaint: If you believe your privacy rights has been violated, you may file a complaint with this clinic's privacy officer, the Office of Civil Rights, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
8. Right to Provide an Authorization for Other Uses and Disclosures: This clinic will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you or your child's PHI may be revoked at any time in writing. After you revoke your authorization, we will not longer use or disclose your PHI for the reason described in the authorization. Please note we are required to retain records of your care.
9. If you have any questions or correspondence : Please contact Melody Charelson, Privacy Officer for Snyder Charleson Therapy Services, P.C.

Effective March 29, 2011

*This form is educational only, does not constitute legal advice, and covers only federal, not state law (August 13, 2002).

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Universal Precautions

1. **Purpose**: The purpose of this policy is to provide information and procedures that will promote the health and safety of employees and clients and reduce the possibility of disease transmission during the delivery of early intervention services. This is good, basic hygiene.

2. **Reference Documents:** Center for Disease Control; New Jersey Dept. of Health and Senior Services; County Health Depts.; Dept. of Education; The Occupational Safety and Health Administration (OSHA); specific agency policy and procedures; LOA and grants (SCHS).

3. **Persons Affected**: This policy applies to EIP direct service staff (consultants), service coordinators, and contractual staff. Any or all persons directly in contact with EIP children and family members.

4. **Policy:** All staff will implement UP to prevent the spread of communicable disease between Clients and employees, between clients, and between employees. The UP is implemented in a manner that respects the privacy of employees and clients. Practitioners are not expected to change diapers or to clean up bodily fluids. This is the expectation of the parent/guardian.

5. **Definitions:** The definition from the Center for Disease Control states the following: "A simple set of effective practices designed to protect health care workers and patients from infection with a range of pathogens including blood borne viruses. These practices are used when caring for all patients regardless of diagnosis."

    a. You may have a child in your caseload that has an infectious disease. You may not know or have been informed of a diagnosis. The body fluids of all persons should be considered to contain potentially infectious agents (germs). The term body fluids includes: blood, semen, respiratory secretions (e.g. nasal drainage) and saliva. Contact with body fluids presents a risk of infection with a variety of germs. In general, however, the risk is very low and dependent on the type of contact made with it. Universal precautions are an infection control method which required employees to assume that all human blood or body fluids are infections. Universal precautions are any chemical or functional barrier which prevents the spread of the infections process. I.E. hand washing, gloves, masks, and disinfecting solutions (bleach).

6. **Responsibility**: Program administers are responsible for ensuring compliance with this policy. All intervention providers are expected to implement the Universal Precautions policy.
7. **Procedure Outline**:
    a. All direct line staff must be initially trained during orientation period (documentation in employee file) with annual training and policy review (documentation will be maintained)
    b. Documentation that training took place
    c. Distribution of all appropriate supplies (gloves, masks, hand sanitizers) to all direct line service practitioners
    d. Observe appropriate hand washing techniques (see Attachment A)
    e. Utilization of gloves (see Attachment B) and appropriate disposal of same
    f. When clinically indicated cleaning of toys being brought into the home (1:10 bleach solution)
    g. Clean up of bodily fluids
    h. Mechanisms for reporting exposure- the practitioner should notify their immediate supervisor

Attachment A: Hand washing techniques- will be performed to prevent cross-contamination between clients and EIP personnel.

- Hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly before and after client contact, if contaminated with body substances, before and after gloves are worn, and before preparing or eating food.
- Use soap, warm water, and friction for hand washing. Lather and scrub for 15-30 seconds. Rinse well, beginning with fingertips, or dirty water runs off at the wrists. Dry hands on a paper towel. Use paper towel to turn off faucets.
- Use a waterless hand washing product for immediate use if hand washing facilities are not available (i.e. Purell or some type of antibacterial solution). Hand washing facilities should be located as soon as possible

Attachment B: Utilization of Gloves (when appropriate- *family needs to be informed why precautions need to be utilized): the use of gloves (intact latex or vinyl) is important where the practitioner has cuts, abraded skin, chapped hands, dermatitis, etc., when examining abrasions or when client has the same.

- Gloves are to be worn by the practitioner when direct contact with any body substance is anticipated (blood, urine, pus, feces, saliva, drainage of any kind)
- Gloves are to be worn when contact with non-intact skin is anticipated
- Remove gloves by pulling down on hands so that soiled surface is inside and disposed of immediately
- Gloves should not be washed or disinfected for reuse

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Attachment C: Toy washing procedure

- The use of toys/equipment found within the home environment should always be first priority. This is to limit exposure to germs and to encourage family follow through with toys available to them.
- It may be necessary or beneficial for a practitioner to introduce new toys to a child for the following clinically acceptable reasons: in order to create excitement about participating in therapy, to create motivation so a child makes an effort to reach a desired result, or to teach a family member what toys and techniques are the most beneficial to bring about a desired result.
- If it is determined clinically beneficial to bring toys into the home environment, they may be left at the home until the child has mastered the skill introduced. If the practitioner finds it impractical to leave the toy in the home, then the toy must be sterilized if used by another person between sessions.
- Methods of sterilization:
    - Use of dishwasher is recommended
    - Submerging toys in 1:10 bleach solution and rinse thoroughly under running water and air dry
    - Use of Clorox or similar wipes over all surfaces. One should never reuse these wipes
    - Separate clean from soiled toys during transport

Attachment D: Incident reporting procedure

***refer to agency policies**