**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Client Paperwork/Consents for Treatment**

[ ]  **Required Client Paperwork**

[ ]  **Behavior Analyst Expectations**

[ ]  **Behavior Assistant Expectations**

[ ]  **Abuse & Neglect Policy**

[ ]  **Authorization to Release Information**

[ ]  **Client Bill of Rights**

[ ]  **Client Information Form**

[ ]  **First Aid Release Form**

[ ]  **Steps for Submitting Grievance**

[ ]  **Title VI Signature Page**

[ ]  **Informed Consent for Treatment**

**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent for Treatment**

The undersigned acknowledges that Company Name, hereinafter referred to as COMPANY NAME, is providing services to, or for the benefit of the below named client and is requiring, as partial consideration for providing said services, the execution of this Informed Consent for Treatment which is being executed by the undersigned as the natural parent, guardian, or other responsible party for the below named patient/client. The specific terms of this Informed Consent for Treatment are as follows:

• COMPANY NAME is providing services including, but not necessarily limited to behavior analysis services, behavior assistant services, evaluation, program development, and treatment of the below named client. • COMPANY NAME will provide the aforementioned services in a professional manner and will take every precaution within reason to insure the safety of the client. • The undersigned herby acknowledges the potential risk of inadvertent injury to the client. COMPANY NAME has informed the undersigned that treatment strategies are often play-based or interactive in nature and accordingly, can potentially pose risk of unintended injury to the client. • The undersigned hereby acknowledges the potential risks of injury based on the strategies implemented by COMPANY NAME and consents to the same despite the disclosed risks. Furthermore, the undersigned herby waives, on behalf of the undersigned as well as the patient, together with the heirs, devisees, or assignees of the undersigned or the patient, any and all liability for personal injury, physical, or otherwise, which may be incurred by the client as a result of the provision of services. • The undersigned acknowledges and agrees that the execution of this form, and the promises and conditions as set forth herein, is partial consideration for the provision of services to the client by COMPANY NAME. • The undersigned acknowledges and agrees that if the status of legal guardian should change, they will immediately notify Company Name, of the name, address, and telephone number of the person who has assumed guardianship of the below-named client • The undersigned acknowledges and agrees that they have legal authority to consent to treatment, release of information, and all legal issues involving the below-named client. Upon request, I will provide Company Name, with proper legal documentation to support this claim.

 By signing below I verify that I have read and understand the above Informed Consent for Treatment, agree to adhere to it, and wish to have COMPANY NAME provide services and that the provision of services will be contingent upon adherence to this agreement and full participation by the caregiver/guardian. If at any time there is not full participation and cooperation by the caregiver/guardian, I understand COMPANY NAME may terminate services following notice of 30 days. I also understand that I may discontinue services at any time and will be held accountable to pay for services rendered up to that point.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Client** \_\_\_\_\_\_\_\_\_\_\_\_\_**Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Caregiver/Guardian** \_\_\_\_\_\_\_\_\_\_\_\_\_**Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Provider** \_\_\_\_\_\_\_\_\_\_\_\_\_**Date**

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorizes Company Name, Company Address, and its subsidiaries, affiliates, and clinicians, the ability to release or obtain protected health information concerning the above named client. Protected health information may relate to my past, present or future physical or mental health condition, and the provision of my health care, or payment for my health care services. This information may be disclosed to obtained from the following agencies (e.g., doctor’s office, school), and their employees (indicate agency name/address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delivery Method: Mail Phone Fax Email**

I authorize ALL Health information to be disclosed OR only the following information is/are authorized for disclosure (check all to be released)[ ] Individual Education Plan (IEP) [ ] Speech/Language Evaluation Client Information Sheet: [ ] Psych Educ. Assessment [ ] Hearing Screening [ ] Individualized Treatment Plan [ ] Report Cards/Transcripts [ ] Medical / Physical History [ ] Treatment Plan Reviews [ ] Behavioral Report [ ] Immunization Record [ ] Psychosocial Evaluation [ ] Special Report [ ] Neurology Report [ ] Behavioral Program [ ] Psychological Evaluation [ ] Psychiatric Evaluation [ ] Discharge Summary [ ] Medication Management Visits [ ] Progress Notes [ ] Progress Summary

**Expiration:** This authorization expires or (exp. Date) Purpose of the Release: At the request of the Individual Assessment Treatment Coordination Disability Determination Other – Please specify To obtain information for Brief Behavioral Health Status Exam

**Other Information:** • I understand that Company Name, cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. • I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Company Name • I understand that I may revoke this Authorization in writing at any time, however, l cannot revoke authorization for action that has already been taken. I further understand that I must provide any notice of revocation in writing to the Business Office at the address listed above.

 A copy of this release shall be valid as the original. THIS CONSENT EXPIRES I YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

**Legal Guardian Name & Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Behavior Analysis Services Expectations**

**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioral Analyst Description:** A Behavioral Analyst provides community-based therapy support services. The Behavioral Analyst provides an assessment for the consumer along with the development of a plan of care and insures the implementation of the plan.

**Behavior Analyst Responsibilities:**

• If requested and approved a Functional Behavioral Assessment (FBA) will be completed within 30 days of receipt of the Personal Service Authorization (PSA). • Development of a Behavior Analysis Service Plan (BASP) that is incorporated into the Individual Service Plan (ISP) will be due within 90 days from receipt of the PSA. • Provides services only within the margins of the PSA. • Submit applicable plans to the Local Review Committee, completes revisions and submits updates as necessary and required. • Implements the BASP as well as train and monitor caregivers. • Collects and analyzes data received from caregivers. • Complete Case Note / Client Contact Log with signed confirmation of services. • Complete Quarterly Service Summaries and Annual Reports in relation to the Support Plan effective date, to include Monthly Graphs. • Submit all Summaries and Reports to Local APD office each month by all required deadline. • Active member of the consumer’s treatment team. • Attendance at the consumer’s ISP meeting when requested. • Regular correspondence with the consumer’s Support Coordinator and relevant caregivers • Coordinate appointments for service delivery. • Provide on-sight services in the home, community, work place or ADT

By signing below I am indicating that I fully understand the role my Behavior Analyst has in providing me with exceptional services. I have also had the responsibilities of the Behavior Analyst explained to me.

**Signature of Client:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Behavior Analyst or Certified BCBA**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_

Company Name

**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior Analysis Services Expectations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioral Assistant or Registered Behavior Technician Description:**

A Registered Behavior Technician provides community-based therapy support services. The Registered Behavior Technician works with a Behavior Analyst to implement the behavior plan, collect data, and train caregivers.

**Behavior Assistant/ Registered Behavior Technician Responsibilities:**

• Provides services only within the margins of the Personal Service Authorization (PSA). • Implements the Behavior Analysis Service Plan (BASP) as well as train and monitor caregivers. • Complete Case Note / Client Contact Log with signed confirmation of services • Complete Quarterly Service Summaries and Annual Reports in relation to the Support Plan effective date, to include Monthly Graphs. • Submit all Summaries and Reports to Local APD office each month by all required deadline. • Active member of the consumer’s treatment team. • Attendance at the consumer’s ISP meeting when requested. • Regular correspondence with the consumer’s Support Coordinator and relevant caregivers • Coordinate appointments for service delivery. • Provide on-sight services in the home, community, work place or ADT

By signing below I am indicating that I fully understand the role my Behavior Assistant has in providing me with exceptional services. I have also had the responsibilities of the Behavior Assistant explained to me.

**Signature of Client:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Registered Behavior Technician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Bill of Rights**:

I have the right to dignity, privacy, and humane care, including the right to be free from sexual abuse in my residence. I have the right to practice my faith. I have the right to receive services which protect my personal liberty and those services will be provided in the least restrictive conditions necessary to achieve the purpose of treatment. I have the right to participate in a program to promote my educational and/or training goals without prejudice of age or disability. I have to the right to sex education, marriage, and family planning when applicable. I have the right to social interaction and participation in community activities. I have the right to physical exercise and recreational activities. I have the right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse or neglect. I have the right to consent to or refuse treatment, subject to the provisions of s. 393.12(2)(a) or chapter 744. I have the right to receive benefits or participate in activities which receive public funds. I have the right to vote. I have the right to unrestricted communication; mail, telephones, visitation, personal possessions (clothing, personal effects), monies (in accordance to s.407.12. Included in my right to have personal possessions will be the access to individual storage space for my private use. I have the right to appropriate medical and dental care. I have the right to humane discipline. NO treatment plan or behavior plan will be used which contain the use of noxious of painful stimuli. My records will remain confidential.

A copy of this Bill of Rights was explained and provided to me.

**Signature of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Caregiver/Guardian**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Company Name Provider**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Client:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Abuse/Neglect Policy**

 All Company Name Personnel are legally and ethically bound to report situation of suspected abuse and/or neglect. Our policy is to report suspected abuse/neglect immediately to the appropriate authorities. The administrator will immediately report such knowledge or suspicion to the central abuse registry and tracking system of the Department of statewide toll-free telephone number.

1-800-ABUSE or TTY users call 1-800-453-5145 condense I understand this policy and by signing acknowledge my agreement with the stipulations in this policy.

**Signature of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_

**Signature of Caregiver/Guardian**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_

**Signature of Company Name Behavior Analysis Provider:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_

**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First Aid Release Form**

I agree to allow personnel of Company Name to administer simple first aide in the form of cleaning and bandaging a cut, burn, or scrape. I understand that Company Name personnel are not authorized to administer medications and medical attention beyond simple bandaging. Any injury that occurs will be referred out to the nearest hospital and/or critical care facility or by dialing 911. Company Name personnel are not authorized to transport injured recipients.

I agree to the terms as stipulated.

**Signature of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_

**Signature of Caregiver/Guardian**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_

**Signature of Company Name Behavior Analysis Provider**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_

**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Company Name, Client and Caregiver/Guardian, As a client of Company Name, you are protected against discrimination by Title VI of the Civil Rights Act of 1964.

Title VI requires that no person in the United States of America shall, on the grounds of race, color, sex, or national origin, be excluded from the participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which a providing company receives federal financial assistance.

Company Name, assures full compliance with Title VI of the Civil Rights Act of 1964, the Civil Rights Restoration Act of 1987, and related statues and regulations in all programs and activities provided.

Any client who believes they have been distressed by an unlawful discriminatory practice under Title VI has a right to file a formal complaint. Any such complaint must be in writing and filed with Company Name, within one hundred eighty (180) days following the date of alleged discriminatory occurrence.

Title VI Complaint Forms can be obtained and/or to register a Title VI complaint please contact our Human Resources and Administration Team at the email address listed below.

emailhandle@companyname.com

Sincerely,

 Company President

**Title VI Receipt Signature**

By signing below I verify that I have received the Title VI letter from Company Name:

**Name of Client**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of Caregiver/Guardian**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of Company Name Provider**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Steps for Submitting Grievance**

**Recipient name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_

Explanation of steps for filing a grievance: 1. Notify Company Name President, of the nature and issue at hand. a. May be reached via cell phone: \_\_\_\_\_\_\_\_\_\_\_\_b. May be reached via email: emailhandle@companyemail.com 2. Provide any documentation you have of the issues at hand. 3. Company Name will do everything to satisfy our clients in any way possible, and promise to address your concern in a timely and effective manner.

**Signature of Client:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Caregiver/Guardian:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Company Name Provider:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grievance Report**

**Recipient name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of report:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of person requesting review**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to recipient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nature of complaint:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resolution:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Resolution:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date sent to: Requestor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WSC:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Others:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_