Social Skills Group Application

August 17, 2020

Dear Parents and Caregivers:

We hope this letter finds you and your families staying safe and healthy. We are following the COVID developments and safety recommendations as they relate to us starting our Social Skills Groups Program. Our vision, at this point, is that we will have a hybrid model. While we are making the preparations for in person groups, we recognize that some families and staff will feel safer joining group virtually vs in person.

We are looking forward to seeing you and your children in the coming weeks.

We are pleased to share that we have reduced the annual registration fee per child to $25.00 and is required at the time the application is submitted. If your child does *NOT* have a Medicaid or RIteCare policy, the fee per group is $30.00 per week. **This fee also applies for participants over 21 years of age.**

Please note that our Scholarship Program is still available to assist with the costs of group for self-pay families. If your child *DOES* have an active Medicaid or RIteCare policy, we will pursue reimbursement from them for services provided to your child.

Please take a moment to review our updated attendance policy/agreement for cancellations and group absences on page 10. To provide the highest quality care to as many children as possible, it is crucial that this policy be followed.

Please call our Children's Programs and Respite Coordinator, Abby Waite if you have any questions or concerns regarding these procedures.

I look forward to seeing many of you both virtually and in person as we move forward with our new normal. Caren, Abby and I are here to listen to any concerns you have about our safety measures and what we might do to make both you and your children feel safe.

Best,

Joanne Quinn
Executive Director

Social Skills Group Application

ICD-10 Medical Diagnosis Code

***If your children are new to The Autism Project, please bring this page to their physician or clinician and ask them to complete the form. Once it filled out and signed, the form can be faxed to The Autism Project's fax number so we can provide Medicaid or RIteCare with the required information. If your child has attended social skills groups at The Autism Project and you've already submitted this form in the past, you do not need to submit the form again.**

Dear Physicians and Clinicians,

Please list your patient's diagnosis and the relevant ICD-10 Codes. We can then enter the accurate medical diagnosis into our Medicaid Database. Please complete the information below and fax it to our offices to the attention of Programs Administrative Assistant, Abby Waite.

Our Fax Number is (401) 785-2272.

Date:
Child's Name:
ICD-10 Diagnosis:
Physician's/Clinician's Printed Name:
Physician's/Clinician's Signature:
Credentials:

Social Skills Group Application

Office Use Only
Client#_____
☐ New ☐ Ret.
☐ M ☐ NHP ☐ UHC ☐ SP
Amt. ____ chk #_____

APPLICATION DEADLINE: SEPTEMBER 30, 2020

GROUPS WILL BEGIN THE WEEK OF OCTOBER 13TH

PERSONAL INFORMATION

Participant's Name:			
DOB:	Grade:	Age:	Gender:
Address:	City:	State:	Zip:
ICD-10 Diagnosis: ☐ Autism Spectrum Disorder ☐ Other			
Please FAX the Physician's Form to 785-2272 to confirm your child's diagnosis. Your child does not have to have a diagnosis of ASD to participate in groups. We need confirmation of the new ICD-10 Code for his/her diagnosis strictly for insurance billing purposes. (See attached Physician's Form)			

PARENT/LEGAL GUARDIAN INFORMATION

Parent #1 Name:		Relationship:	
Address:	City:	State:	Zip:
E-mail:	Home#:	Cell#:	
Parent #2 Name:		Relationship:	
Address:	City:	State:	Zip:
E-mail:	Home#:	Cell#:	
Please indicate the primary contact person	☐ Parent#1	☐ Parent#2	☐ Both
How do you prefer The Autism Project contact you?	☐ Phone	☐ Email	☐ Mail at your home address

Please list any group(s) your child has previously attended at The Autism Project:

WHAT TYPES OF GROUPS WOULD YOU LIKE YOUR CHILD TO PARTICIPATE IN?

Foundational Group Skills:

- ☐ Move & Groove
- ☐ Leaps & Bounds
- ☐ Skills for Life

Arts:

- ☐ Creative Expressions (art)
- ☐ Curtain Call (theater)
- ☐ In Harmony (music)
- ☐ Movie Making

Recreational/Leisure Groups:

- ☐ Game On! Karate
- ☐ Game On! Basketball
- ☐ Game On! Dance

Middle/High School & Young Adult:

- ☐ Club Jr.
- ☐ Club

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Participant Name: _____

EMERGENCY & MEDICAL INFORMATION

Please attach a recent photograph of your child

Emergency Contact #1 Name:		
Relationship:	Home#:	Cell#:
Emergency Contact #2 Name:		
Relationship:	Home#:	Cell#:

Physician's Name:	Phone#:
Current Medications:	
Allergies:	
Food Restrictions:	
Seizures (yes/no):	
Other:	
In case of emergency, I understand that every effort will be made to contact me, or the contact people listed above. If I cannot be reached, I understand that staff will use a standard 911 protocol and have my child taken to the nearest hospital.	
Signature of Parent/Guardian:	**Date:**

Social Skills Group Application

Participant Name: _____

Please help us get to know your child by providing the following information.

SUPPORT NETWORK

Is your child receiving HBTS? _____

SCHOOL INFORMATION

School name and district: _____

What kind of school does your child attend?

- ☐ Public
- ☐ Home School
- ☐ Private

Does your child have an Individual Education Plan? (IEP)

- ☐ Yes
- ☐ No

What type of classroom is your child in?

- ☐ Mainstream
- ☐ Inclusion
- ☐ Self-contained
- ☐ Other: _____

Does your child have a 1:1 classroom assistant?

- ☐ Yes
- ☐ No

Has your child had experience (past or present) with any of the following:

- ☐ Visual Schedules
- ☐ First/Then Boards
- ☐ Social Stories
- ☐ Work Systems
- ☐ Chewing Gum
- ☐ Headphones
- ☐ Relaxation Protocols
- ☐ Weighted Materials
- ☐ Other: _____

Social Skills Group Application

Participant Name: _____

What are your child's favorite activities or interests? (movies, characters, foods, games, music, etc)

_____

_____

Does your child have any specific dislikes? (sounds, smells, touch, movement, foods, etc)

_____

_____

SOCIAL EMOTIONAL (please check all that apply to your child)

My child has difficulty:

- ☐ Engaging in play or leisure activities with peers
- ☐ Taking turns/sharing
- ☐ Maintaining personal space of self/others
- ☐ Commenting on the environment to others (describes, labels, names)
- ☐ Engaging in activities that are not highly preferred
- ☐ Recognizing how his/her behavior effects others
- ☐ Identifying problems/conflict
- ☐ Identifying solutions and potential consequences to problems/conflict
- ☐ Recognizing his/her own emotions
- ☐ Recognizing other's emotions
- ☐ Utilizing appropriate coping strategies when upset

COMMUNICATION LEVEL (please check all that apply to your child)

My child:

- ☐ Is verbal
- ☐ Is nonverbal
- ☐ Uses an augmentative communication system/device (please specify): _____
- ☐ Follows verbal/nonverbal directions
- ☐ Utilizes visual supports to follow directions
- ☐ Indicates his/her likes and dislikes
- ☐ Makes requests for his/her basic wants and needs

Social Skills Group Application

Participant Name: _____

CHALLENGING BEHAVIORS (check all that apply to your child and describe as needed)

My child may:

- ☐ Run away
- ☐ Act aggressively towards self/others: _____
- ☐ Shut down/withdraw
- ☐ Be non-compliant
- ☐ Inappropriately touch self/others
- ☐ Is self-injurious: _____
- ☐ Other: _____

SENSORY (please check all that apply to your child)

My child:

- ☐ Avoids or seeks touch from others (please circle which)
- ☐ Avoids or seeks messy play such as playdoh, glue and paint (please circle which)
- ☐ Plays rough in play/leisure activities
- ☐ Avoids participation in sports or active games
- ☐ Craves or avoids movement (please circle which)
- ☐ Seems to be in constant motion (loves spinning, swinging, being upside down)
- ☐ Cannot process or tolerate extremes of intensity such as color, light etc.
- ☐ Is over or under sensitive to sounds (please circle which)
- ☐ Eats non-edible items
- ☐ Dislikes strong smells/tastes

ACTIVITIES OF DAILY LIVING (ADLS) (please check all that apply to your child)

My child is NOT yet independent in the following areas:

- ☐ Dressing/Bathing
- ☐ Eating
- ☐ Ambulating (walking)
- ☐ Toileting
- ☐ Hygiene
- ☐ Shopping
- ☐ Daily Chores
- ☐ Money Management
- ☐ Food Preparation/Meds
- ☐ Telephone/Transportation

Social Skills Group Application

PLEASE LIST THE GOALS THAT YOU HAVE OR THE SKILLS THAT YOU WOULD LIKE TO SEE YOUR CHILD IMPROVE UPON THROUGH PARTICIPATION IN A SOCIAL SKILLS GROUP:

_____

_____

_____

Social Skills Group Application

Lifespan

☒ Interview ☒ Video ☒ Photography ☒ Broadcast

Date: 2020-2021

Authorization and Release
For Photography/Audio and Videotaping/ Broadcasting/Interviewing (When Protected Health Information is Involved)

Initial Use: **The Autism Project's Social Groups**

Patient description_____

use if multiple patients photographed for initial use. Ex yellow shirt, tall, etc.

Patient Name (please print): _____

Patient Address (city/state zip): _____

Patient Date of Birth: _____ **Patient Phone #:** _____ **Patient Email:** _____

As applicable and as further described below, I authorize Lifespan and its affiliates to photograph, video and/or audiotape, and/or interview me, or I agree to take part in any radio or TV programs (the "Permitted Interaction"). Describe nature of Permitted Interaction (i.e., context of interview, event at which photos are to be taken, etc.) and nature of protected health information to be gathered about patient:

Pictures and videos taken during the social groups and related outings. Photos/videos may be used on TAP's website, Facebook or Twitter accounts, or for training purposes. They may also be used for publicity in local papers and / or on the website to publicize the groups and related activities.

I authorize the Lifespan Marketing and Communications department to (1) identify me by name in any photographs, videos and/or audio tapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction, and (2) to use or disclose such materials (along with my name) for display in print, radio, TV or internet media or other form of media for advertising, marketing, fundraising, promotional and educational purposes (the "Permitted Use"), and (3) to use and disclose such materials as necessary to effectuate the Permitted Use (i.e. to employees of newspapers or radio stations).

I authorize Lifespan and its affiliates to copyright any photographs, videos, and/or audiotapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction.

I understand that, to the extent the content of the Permitted Interaction contains my protected health information, this information is protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

I understand that if the person or entity that receives my protected health information (as applicable) is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan from all liability arising from this disclosure of my health information.

I understand this authorization will expire ten (10) years from the date signed below. Prior to the expiration date, I understand I may revoke this authorization by notifying, in writing:

Lifespan Marketing and Communications
117 Ellenfield Street, Suite 100
Providence, Rhode Island 02905

I understand that any previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits at Lifespan.

This form must be fully complete before signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Patient's Name

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

Social Skills Group Application

Participant Name: _____

CONSENT TO INITIAL SERVICES

I have come to The Autism Project, or I have brought my child/ward to The Autism Project, for autism spectrum disorder, social emotional and/or communication services to be provided by licensed therapists (LICSW, Occupational Therapist, Speech and Language Pathologist) and TAP staff. I agree to participate in the development of my or my child's/ward's treatment plan. When I sign the treatment plan, I will be consenting to the services outlined in it. I, or my child/ward, will not be included in any research unless we give our informed consent as required by law.

By signing below, I consent to services, such as evaluations and assessments, typically undertaken to prepare a treatment plan. The consent I give here will end when I sign my or my child/ward's treatment plan.

Signature of parent/guardian: Date:

Printed name of parent/guardian:

AGREEMENT TO PAYMENT & ATTENDANCE

Authorization for Payment

The Autism Project provides social skills groups and specialized treatment for children through an established fee structure. If your child does ***NOT*** have a Medicaid or RIteCare policy, the fee per group is $30 per week. This fee will be prorated if your child is placed in a group after the start date. If your child ***DOES*** have an active Medicaid or RIteCare policy, we will pursue reimbursement from them for services provided to your child. Additional fees (such as materials costs etc.) may apply depending on the specific group and are not covered by your child's policy.

Cancellations and/or Group Absences (Compliance with Treatment)

Participation in our therapeutic groups is a critical component of your child's therapy. To provide the highest quality care to as many children as possible, we have created the following agreement for our families:

-Notification of at least one business day is required for a group cancellation. A $25 fee will be charged after 2 late cancellations and/or 2 group absences.
- Late cancellation and group absence fees are billed to you and are not reimbursed by your insurance company. These payments must be made prior to the next scheduled group date. (Due to state regulations, late cancellation and/or group absence fees do not apply to children who have Medicaid or RIteCare policies).
-We understand children get sick and unforeseen circumstances arise; however, if there are more than 2 episodes of late cancellation and/or group absences, we may choose to discontinue treatment for the session. In the case of a history of late cancellations and/or missed appointments, future services may not be provided.

Our groups have a waiting list throughout the year and our goal is to place as many children as possible. To report a cancellation, please call Abby Waite at 785-2666 ext. 76797 or our front desk at 785-2666 ext. 76784.

By signing below, I understand the above policies and procedures and authorize The Autism Project to bill Medicaid, me, or my insurance company as designated on the payment page. I also understand that if my child loses his/her Medicaid I will be responsible for paying my child's group fees.

Signature of parent/guardian: Date:

Printed name of parent/guardian:

Social Skills Group Application

Participant Name: _____

PERMISSION TO PICK UP CHILD

Please complete the following information in the event that someone other than yourself may pick up your child from a social skills group. Group staff will refer to this information at the time of group dismissal.

- You must notify group staff in advance of who will be picking up your child if he or she is not on the list.
- We will ask that person to present his/her identification before releasing your child to him/her.
- All individuals picking up a child are required to come into the building and to sign-out with a staff person before leaving.

Name	Relationship	Phone #

Signature of Parent/Guardian: Date:

Printed Names of Both Parents/Guardians:

PERMISSION FOR RESTRICTIVE PROCEDURES

The Autism Project uses evidenced-based strategies that are designed to establish a supportive and safe environment that will prevent your child from having behavioral difficulties. There may be rare occasions when the physical safety of your child, other participants, and staff is at risk. When this type of incident occurs, it may be necessary to physically hold your child to prevent harm, and to help her/him feel safe. Staff will only use approved therapeutic holds/restraints for which they have been trained. The hold is only maintained for as long as it takes for your child to begin to regain emotional and physical control so that s/he can move to a quieter area until they are able to rejoin the group. These procedures are carried out in a calming, supportive, and non-punitive manner. You will be notified when you pick up your child of the intervention so that you can assist staff in processing the incident and supporting your child.

I understand that the above procedures will be implemented only for the purpose of safety and in accordance with the stated guidelines.

Signature of parent/guardian: Date:

Printed name of parent/guardian:

APPLICATION & PLACEMENT PROCESS

Parents/Caregivers must complete a group application each year. Upon receipt of your child's application, the program coordinators will schedule a brief intake appointment to review group offerings and family goals to assist with placement. Our program coordinators base placement decisions on a variety of factors including age, individual needs, abilities and interests. You will be contacted about your child's placement in group prior to the start of the session. Whenever possible, we will try to accommodate your group preferences.

I understand I must complete a group application each year and that The Autism Project will try to accommodate my group preferences.

Signature of parent/guardian: Date:

Printed name of parent/guardian:

Social Skills Group Application

Demographic Survey

The information requested is for data purposes only. Please do not include you or your child's name on this form

Participant's Sex ☐ male ☐ female ☐ other ☐ prefer not to answer

Participant's Age ☐ 5-8 ☐ 9-12 ☐ 13-16 ☐ 17-20 ☐ 21 and up (Please specify) _____

Household Income Range (Please consider all who live in and contribute money to the household)
☐ $0-$19,999 ☐ $20,000-$34,999 ☐ $35,000-$49,999 ☐ $50,000+ ☐ prefer not to answer

Race (please check all that apply) ☐ American Indian or Alaska Native ☐ African American or Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ prefer not to answer

Ethnicity (please check one) ☐ Hispanic or Latino or Spanish Origin[a] ☐ Not Hispanic or Latino or Spanish Origin ☐ prefer not to answer
[a] Defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Primary Diagnosis(Child 1) ☐ Autism Spectrum Disorder ☐ Autism ☐ Childhood Disintegrative Disorder ☐ Retts Syndrome ☐ Fragile X ☐ Non-Verbal Learning Disorder ☐ PDD ☐ PDD-NOS ☐ High Functioning Autism ☐ Asperger Syndrome ☐ Downs Syndrome ☐ Intellectual Disability ☐ Developmental Disability ☐ Other_____

Primary Diagnosis(Child 2) ☐ Autism Spectrum Disorder ☐ Autism ☐ Childhood Disintegrative Disorder ☐ Retts Syndrome ☐ Fragile X ☐ Non-Verbal Learning Disorder ☐ PDD ☐ PDD-NOS ☐ High Functioning Autism ☐ Asperger Syndrome ☐ Downs Syndrome ☐ Intellectual Disability ☐ Developmental Disability ☐ Other_____

Preferred Language spoken in your home:
☐ English ☐ Spanish ☐ Portuguese ☐ Arabic ☐ Creole ☐ Swahili ☐ Hindi ☐ Mandarin
☐ Other: _____ ☐ prefer not to answer

Social Skills Group Application

PAYMENT INFORMATION

Participant Name:	**Social Security #:** **(We are not able to process the application without this)**	
Parent Name:		
Address:		
City:	**State:**	**Zip:**
CEDAR Center:		

METHOD OF PAYMENT FOR $25 APPLICATION FEE (due for all applicants; non-refundable)

☐ Check ☐ Money Order ☐ PayPal	Amount enclosed:	
☐ Credit Card #	Exp. Date:	CVV Code:
Cardholder's Name:		
Cardholder's Billing Address:		

METHOD OF PAYMENT FOR PROGRAM FEE ($30 per week)

☐ Katie Beckett, Adoption Subsidy, SSI

Medicaid Member ID: * **PLEASE INCLUDE COPY OF CARD**

RIteCare through (please check one): * **PLEASE INCLUDE COPY OF BOTH CARDS**

☐ Neighborhood Health Plan of RI

Member ID:

Medicaid Member ID:

☐ United Healthcare

Member ID:

Medicaid Member ID:

☐ Self-Pay **(An invoice will be mailed to your home address with the total amount due for the session.)**

☐ Scholarship: If you need financial assistance, please complete an application for a scholarship and submit at least 2 weeks prior to the start of groups.

I authorize The Autism Project to process my payment as indicated above.

Parent/Guardian Signature: Date:

FOR OFFICE USE ONLY

☐ Payment Received:__/__/__ $_____ Initials:_____ ☐ Medicaid Eligible: ☐ yes ☐ no

☐ Scholarship Application Received: ___/___/___ Amount Awarded: _____ for ___ groups