



# 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

**APPLICATION DEADLINE: SEPTEMBER 30, 2021**

**GROUPS WILL BEGIN THE WEEK OF OCTOBER 11<sup>TH</sup>**

| Office Use Only              |   |
|------------------------------|---|
| Client#                      | _____   |
| <input type="checkbox"/> New | <input type="checkbox"/> Ret.   |
| <input type="checkbox"/> M   | <input type="checkbox"/> NHP <input type="checkbox"/> UHC <input type="checkbox"/> SP |
| Amt.                         | <input type="text"/> chk # _____  |

## PERSONAL INFORMATION

|  |        |        |         |
|--|--------|--------|---------|
| <b>Participant's Name:</b>   |        |        |         |
| DOB:   | Grade: | Age:   | Gender: |
| Address:   | City:  | State: | Zip:    |
| <b>ICD-10 Diagnosis:</b> <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Other  |        |        |         |
| Please FAX the Physician's Form to 785-2272 to confirm your child's diagnosis. We need confirmation of the new ICD-10 Code for his/her diagnosis for insurance billing purposes. (See attached Physician's Form) |        |        |         |

## PARENT/LEGAL GUARDIAN INFORMATION

|   |        |               |      |
|---|--------|---------------|------|
| <b>Parent #1 Name:</b>  |        | Relationship: |      |
| Address:  | City:  | State:        | Zip: |
| E-mail:   | Home#: | Cell#:        |      |
| <b>Parent #2 Name:</b>  |        | Relationship: |      |
| Address:  | City:  | State:        | Zip: |
| E-mail:   | Home#: | Cell#:        |      |
| <b>Please indicate the primary contact person</b> <input type="checkbox"/> Parent#1 <input type="checkbox"/> Parent#2 <input type="checkbox"/> Both                       |        |               |      |
| <b>How do you prefer The Autism Project contact you?</b> <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> 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

**Participant Name:** \_\_\_\_\_



# Social Skills Group Application

## EMERGENCY & MEDICAL INFORMATION

*Please attach a recent photograph of your child*



|  |        |              |
|--|--------|--------------|
| <b>Emergency Contact #1 Name:</b>  |        |              |
| Relationship:  | Home#: | Cell#:       |
| <b>Emergency Contact #2 Name:</b>  |        |              |
| Relationship:  | Home#: | Cell#:       |
| <b>Physician's Name:</b>   |        | Phone#:      |
| <b>Current Medications:</b>  |        |              |
|  |        |              |
| <b>Allergies:</b>  |        |              |
|  |        |              |
| <b>Food Restrictions:</b>  |        |              |
| <b>Seizures (yes/no):</b>  |        |              |
| <b>Other:</b>  |        |              |
| 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. |        |              |
| <b>Signature of Parent/Guardian:</b>   |        | <b>Date:</b> |



# 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:**

- |  |   |
|--|---|
| <input type="checkbox"/> Visual Schedules  | <input type="checkbox"/> Chewing Gum          |
| <input type="checkbox"/> First/Then Boards | <input type="checkbox"/> Headphones           |
| <input type="checkbox"/> Social Stories    | <input type="checkbox"/> Relaxation Protocols |
| <input type="checkbox"/> Work Systems      | <input type="checkbox"/> Weighted Materials   |
| <input type="checkbox"/> 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:**

- |   |   |
|---|---|
| <input type="checkbox"/> Dressing/Bathing     | <input type="checkbox"/> Shopping                 |
| <input type="checkbox"/> Eating               | <input type="checkbox"/> Daily Chores             |
| <input type="checkbox"/> Ambulating (walking) | <input type="checkbox"/> Money Management         |
| <input type="checkbox"/> Toileting            | <input type="checkbox"/> Food Preparation/Meds    |
| <input type="checkbox"/> Hygiene              | <input type="checkbox"/> 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 RItCare 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 RItCare 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 RItCare 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<sup>a</sup>     Not Hispanic or Latino or Spanish Origin     prefer not to answer

<sup>a</sup> 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 #:<br>(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)

|  |                                      |                                 |                  |
|--|--------------------------------------|---------------------------------|------------------|
| <input type="checkbox"/> Check         | <input type="checkbox"/> Money Order | <input type="checkbox"/> PayPal | Amount enclosed: |
| <input type="checkbox"/> Credit Card # | Exp. Date:                           | CVV Code:                       |                  |
| Cardholder's Name:                     |                                      |                                 |                  |
| Cardholder's Billing Address:          |                                      |                                 |                  |

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

|  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Katie Beckett, Adoption Subsidy, SSI  |  | <b>* PLEASE INCLUDE COPY OF CARD</b>       |  |
| <b>Medicaid Member ID:</b>   |  |  |  |
| RItCare through (please check one):  |  | <b>* PLEASE INCLUDE COPY OF BOTH CARDS</b> |  |
| <input type="checkbox"/> Neighborhood Health Plan of RI  | <input type="checkbox"/> United Healthcare |  |  |
| <b>Member ID:</b>  | <b>Member ID:</b>                          |  |  |
| <b>Medicaid Member ID:</b>   | <b>Medicaid Member ID:</b>                 |  |  |
| <input type="checkbox"/> Self-Pay (An invoice will be mailed to your home address with the total amount due for the session.)  |  |  |  |
| <input type="checkbox"/> 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. |  |  |  |
| <b>I authorize The Autism Project to process my payment as indicated above.</b>  |  |  |  |
| Parent/Guardian Signature:   |  | Date:                                      |  |

### FOR OFFICE USE ONLY

Payment Received: \_\_\_/\_\_\_/\_\_\_ \$\_\_\_\_\_      Initials: \_\_\_\_\_       Medicaid Eligible:  yes  no  
 Scholarship Application Received: \_\_\_/\_\_\_/\_\_\_      Amount Awarded: \_\_\_\_\_ for \_\_\_ groups