Social Skills Group Application

July 1, 2023

Dear Parents and Caregivers:

Welcome back to another year of Social Skills Groups at The Autism Project! We have arranged a full schedule of groups and look forward to seeing you and your children.

The annual registration fee per child is $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 $40.00 per week. An additional fee may be added if your child requires one-to-one support. **This fee also applies for participants 21 years of age and older.**

Please note that our Sliding Scale 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 9. To provide the highest quality care to as many children as possible, it is crucial that this policy be followed.

Please call or email our Program Supervisor, Cathy Young for any questions about our groups at 401-667-6787 or catherine.young@lifespan.org.

I wish you well,

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 Program Coordinator, Marissa Sands.

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:

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

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APPLICATION DEADLINE: SEPTEMBER 8, 2023

GROUPS WILL BEGIN THE WEEK OF OCTOBER 9TH

PERSONAL INFORMATION

Participant's Name:		Pronouns:	
DOB:	Grade:	Age:	Gender:
Address:	City:	State:	Zip:
ICD-10 Diagnosis: ☐ Autism Spectrum Disorder ☐ Other			
Please FAX the ICD-10 to 785-2272 to confirm your child's diagnosis. If your child has previously attended groups, we do not require an update unless a change has occurred. (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			
Cell # to enroll in text alerts:			

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

Recreational/Leisure Groups:

☐ Game On! Karate ☐ Game On! Basketball

Middle/High School & Young Adult:

☐ Club Jr. ☐ Club

Arts:

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

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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.

SCHOOL INFORMATION

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

☐ Chewing Gum ☐ Headphones ☐ Weighted Materials

☐ Relaxation Protocols ☐ Work Systems ☐ Other

INTERESTS

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)

_____

_____

_____

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Participant Name: _____

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
- ☐ Engaging in activities that are not highly preferred
- ☐ Recognizing how his/her behavior effects others
- ☐ Identifying problems/conflict
- ☐ Recognizing his/her own/others' emotions
- ☐ Making transitions between activities
- ☐ 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
- ☐ Indicates his/her likes and dislikes
- ☐ Utilizes visual supports to follow directions
- ☐ Makes requests for his/her basic wants and needs

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

My child may:

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

SENSORY (please circle all that apply to your child)

My child responds as follows:

Tactile Input……	Over responds	Under responds	Seeks
Visual Input……	Over responds	Under responds	Seeks
Auditory Input……	Over responds	Under responds	Seeks
Proprioceptive – deep pressure to muscles and joints…	Over responds	Under responds	Seeks
Vestibular – movement……	Over responds	Under responds	Seeks
Taste & Smell……	Over responds	Under responds	Seeks

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Participant Name: _____

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

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:

_____

_____

_____

_____

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Lifespan ☒ Interview ☒ Video ☒ Photography ☒ Broadcast

Date: 2023-2024

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

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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 $40 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 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 3 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 Marissa Sands 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:

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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

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PAYMENT INFORMATION

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

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

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

METHOD OF PAYMENT FOR PROGRAM FEE ($40 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