ICD-10 Medical Diagnosis Code

If you are new to The Autism Project, please bring this form to your adult's physician or clinician and ask them to complete the form. If your adult has attended social skills groups at The Autism Project in the past and you have already submitted this form, 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. Please complete the information below and fax it to our office to the attention of Marissa Sands.

Our Fax Number is 401-785-2272.

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

ADULT PROGRAMMING APPLICATION

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

ADULT'S PERSONAL INFORMATION

Name:		**Pronouns:**	
Date of Birth:		**Age:**	**Gender:**
Address:	**City:**	**State:**	**Zip:**
Phone Number:	**Email:**		
ICD-10 Diagnosis: ☐ Autism Spectrum Disorder ☐ Other: _____			
Please FAX the Physician's Form to The Autism Project at 401-785-2272 to confirm your adult's diagnosis. Please see the attached Physician's Form.			

PARENT/LEGAL GUARDIAN INFORMATION

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

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

Please list any group(s), if any, that your adult previously attended at The Autism Project:

MEDICAL INFORMATION

Please attach a recent photograph of your adult here.

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

Name: _____ Date: _____

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

SCHOOL/JOB/TRAINING INFORMATION

School/Job/Training Name: _____

What type of school did your adult attend?

- ☐ Public: _____
- ☐ Home School
- ☐ Private: _____

Does your adult receive support funded by BHDDH?

- ☐ Yes
- ☐ No

What type of program is your adult currently in (if any)?

- ☐ Day Program with an organization: _____
- ☐ Day Program and Job Coaching with an organization: _____
- ☐ Day Program self-directed
- ☐ Other: _____

Does your adult have 1:1 support in the community and your program?

- ☐ Yes
- ☐ No

Does your adult have experience (past or present) with any of the following?

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

What are your adult's favorite activities or interests? (Movies, characters, foods, games, music, activities, etc.)

_____

_____

Does your adult have any specific dislikes? (Sounds, smells, touch, movement, foods, activities, etc.)

_____

_____

SOCIAL EMOTIONAL (please check all that apply)

My adult may have difficulty:

- ☐ Engaging in play or leisure activities with peers
- ☐ Taking turns/sharing
- ☐ Maintaining personal space of others
- ☐ Commenting on the environment to others (describe, label, name)
- ☐ Engaging in activities that are not highly preferred
- ☐ Recognizing how my behavior affects others
- ☐ Identifying problems/conflict
- ☐ Identifying solutions and potential consequences to problems/conflict
- ☐ Recognizing my own emotions
- ☐ Recognizing other's emotions
- ☐ Utilizing appropriate coping strategies when upset
- ☐ Asking for help
- ☐ Making transitions
- ☐ Other: _____

COMMUNICATION (please check all that apply)

My adult…

- ☐ is speaking
- ☐ is non-speaking
- ☐ has limited or unreliable language
- ☐ uses ASL, pictures or an augmentative communication system/device (circle one or more)
- ☐ follows verbal and/or nonverbal directions (circle one or both)
- ☐ follows one-step directions
- ☐ utilizes visual supports to follow directions
- ☐ follows multi-step directions
- ☐ makes requests for their basic wants and needs
- ☐ indicates their likes and dislikes

SENSORY (please check all that apply)

Sometimes my adult may:

- ☐ Avoid or seek touch from others (please circle one)
- ☐ Avoid or seek messy play such as playdoh, glue, paint, etc. (please circle one)
- ☐ Play rough in play/leisure activities
- ☐ Avoid participation in sports or active games
- ☐ Crave or avoid movement (please circle one or both)
- ☐ Seem to be in constant motion (loves spinning, swinging, being upside down, etc.)
- ☐ Be unable to process or tolerate extremes of intensity such as color, light, sound, etc.
- ☐ Be over or under sensitive to sounds (please circle one or both)
- ☐ Eat non-edible items
- ☐ Dislike strong smells and/or tastes (circle one or both)
- ☐ Other: _____

When I am upset or heightened: (check all that apply and describe as needed)

My adult may:

- ☐ Elope/run away
- ☐ Act aggressively towards myself and/or others (circle one or both). Please describe: _____

_____

- ☐ Shut down/withdraw
- ☐ Become non-compliant/have difficulty following directions
- ☐ Destroy property
- ☐ Inappropriately touch self and/or others (circle one or both). Please describe: _____

_____

- ☐ Engage in self-injurious acts. Please describe: _____

_____

- ☐ Other: _____

_____

Do you have any safety concerns?

_____

_____

ACTIVITIES OF DAILY LIVING (ADLs) (please check all that apply)

My adult may NOT yet be independent in the following areas:

- ☐ Dressing
- ☐ Bathing
- ☐ Eating
- ☐ Ambulating (walking)
- ☐ Toileting
- ☐ Personal hygiene
- ☐ Taking medication
- ☐ Transportation
- ☐ Shopping
- ☐ Daily chores
- ☐ Money management
- ☐ Food preparation
- ☐ Telephone use
- ☐ Applying for jobs

Please list or explain the GOALS that you have for the program and the SKILLS that you would like your adult to work on through participation in Unity Community.

_____

_____

_____

_____

_____

_____

APPLICATION & PLACEMENT PROCESS

Group applications must be complete before starting groups. Upon receipt of the application, the program facilitators will schedule a brief intake appointment with the family/member to review the program and family/member's goals to assist with placement. Our program facilitators base placement decisions on a variety of factors including individual strengths, needs, and interests. You and your adult will be contacted about placement in a group prior to starting. Whenever possible, we will try to accommodate your group preferences.
I understand I must complete a group application, participate in an intake meeting, and that The Autism Project will try to accommodate my group preferences. Signature of parent/guardian: Date:
Printed name of parent/guardian:

Payment Information: Unity Group Pricing/Payment Options

- Invoices are sent out in 11/12-week sessions. There are four sessions per year.

- **Group costs**:
  - Day groups: Monday, Tuesday, Wednesday, and Friday groups - $80 per group
  - Evening group: Wednesday - $60 per group

- **Payment options**:
  - Self-Pay
  - BHDDH Self-directed through the adult's financial payee: Perspectives, Fogarty, Trudeau, West Bay, Works For Me, Options, etc. Discuss with plan writer if group costs can be added to the adult's budget.
  - Public schools may also pay for participants to attend
  - Scholarships may be awarded on a sliding scale (based on income) for the self-pay payment option. Email Marissa Sands for more information at marissa.sands@brownhealth.org

☐ **Self-Pay:** I agree to pay the full cost of the program. Invoices will be mailed to your home address with the total amount due for the session every 11/12 weeks.
☐ **BHDDH Self-Directed Funding** Financial Payee Organization:_____
☐ I would like to request a sliding scale scholarship application. Scholarships may be awarded on a sliding scale based on income. This is only an option if you are paying with the self-pay option.
I authorize The Autism Project to process my payment as indicated above. Signature: Date:

- Payment plans may be set up with Marissa Sands.
  - Email: Marissa.sands@brownhealth.org
  - Phone: 401-667-6797