ICD-10 Medical Diagnosis Code

If you are new to The Autism Project, please bring this form to your physician or clinician and ask them to complete it. If you have 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 #_____

PERSONAL INFORMATION

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

PARENT/LEGAL GUARDIAN INFORMATION (IF APPLICABLE)

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 you have previously attended at The Autism Project:

MEDICAL INFORMATION

Please attach a recent photograph of yourself 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 have listed. 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: _____ Date: _____**

Name: _____ Date: _____

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

SCHOOL/JOB/TRAINING INFORMATION

School/Job/Training Name: _____

What type of school did you attend?

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

Do you receive support funded by BHDDH?

- ☐ Yes
- ☐ No

What type of program are you currently in (if any)?

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

Do you have 1:1 support in the community and your program?

Community:	Program:
☐ Yes	☐ Yes
☐ No	☐ No

Do you 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 favorite activities or interests? (Movies, characters, foods, games, music, activities, etc.)

_____

_____

Do you have any specific dislikes? (Sounds, smells, touch, movement, foods, activities, etc.)

_____

_____

SOCIAL EMOTIONAL (please check all that apply)

I 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)

- ☐ I am speaking
- ☐ I am non-speaking
- ☐ I have limited or unreliable language
- ☐ I use ASL, pictures, or augmentative communication system/device: _____
- ☐ I follow verbal and/or nonverbal directions (circle one or both)
- ☐ I utilize visual supports to follow directions
- ☐ I follow one-step directions
- ☐ I follow multi-step directions
- ☐ I indicate my likes and dislikes
- ☐ I make requests for my basic wants and needs

SENSORY (please check all that apply)

Sometimes I 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: (please check all that apply and describe as needed)

I may:

- ☐ Elope/run away
- ☐ Act aggressively towards others. 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)

I 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 to work on through participation in Unity Community.

_____

_____

_____

_____

_____

_____

APPLICATION & PLACEMENT PROCESS

You must complete a group application before starting groups. Upon receipt of your application, the program facilitators will schedule a brief intake appointment with you to review the program and your goals to assist with placement. Our program facilitators base placement decisions on a variety of factors including individual strengths, needs, and interests. You will be contacted about your placement in 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: Date:
Printed Name:

Payment Information: Adult Programing Group Pricing/Payment Options

- Invoices are sent out in 11/12-week sessions (every three months). 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: Perspectives, Fogarty, Trudeau, Works For Me, Options, etc. Discuss with plan writer if group costs can be added to the member's budget.
  - Public schools may also pay for participants to attend
  - Scholarships may be awarded on a sliding scale (based on income). Email Marissa Sands for more information at marissa.sands@brownhealth.org

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