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 Manisha Negi.

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:

The Autism Project - 1516 Atwood Avenue, Johnston, RI 02919 - Unity Office Phone: 401.667.6783

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			
Preferred language:		**Translator needed?** ☐ Yes ☐ No	
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) that you have attended at The Autism Project in the past (if any).

_____

_____

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:**

ADULT PROGRAMMING APPLICATION

Name: _____ **Date:** _____

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

School/Job/Training Name:

What type of school did your adult attend?

☐ Public: _____

☐ Home School

☐ Private: _____

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 their program/community?

☐ Yes

☐ No

If **yes**, does your adult have support staff that would accompany them to Unity Community?

☐ Yes

☐ No

Does your adult receive support funded by BHDDH?

☐ Yes ISP plan date: _____

☐ No

Does your adult have transportation? If you answered *YES,* please check which option applies to you.

☐ Yes Drives self: _____ Gets ride from someone: _____ Takes RIDE/RIPTA: _____

☐ No

ADULT PROGRAMMING APPLICATION

Name: _____ **Date:** _____

INTERESTS:

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.)

_____

_____

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

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

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: _____

Name: _____ **Date:** _____

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
- ☐ follows multi-step directions
- ☐ utilizes visual supports to follow 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: _____

Name: _____ **Date:** _____

When my adult is anxious, 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/others (circle one or both). Please describe:
- ☐ Engage in self-injurious acts. Please describe:

_____

- ☐ Other: _____

Do you have any safety concerns? ☐ Yes (please explain) ☐ No

_____

_____

_____

_____

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.

ADULT PROGRAMMING APPLICATION

Name: _____ **Date:** _____

CONSENT TO SERVICES

I consent to services from The Autism Project related to autism spectrum disorder, social emotional needs, and/or communication needs to be provided by licensed therapists (Licensed Social Worker, Occupational Therapist, Speech and Language Therapist), Educators, or The Autism Project staff. I agree to participate in the development of my treatment plan. When I sign my treatment plan, I will be consenting to the services outlined in it. I will not be included in any research unless I give my informed consent as required by law.

By signing below, I consent to the services stated above.

Signature: Date:

Printed Name:

APPLICATION & PLACEMENT PROCESS

Group applications must be complete before starting groups. Upon receipt of the application, the application will be reviewed, funding will be confirmed, and an intake meeting will take place. During the intake meeting the program facilitators will review the program and your goals to assist with placement in one of our groups. 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 a group prior to starting.

Please note: participation only starts after confirmation of funding through BHDDH or self-pay

I understand I must complete a group application, participate in an intake meeting, and confirm funding before starting the Unity Community program.

Signature of parent/guardian: Date:

Printed name of parent/guardian:

AGREEMENT TO PAYMENT & ATTENDANCE

Authorization for Payment

The Autism Project provides adult programming through an established program fee-based structure. The program fees are outlines below.

- Day time groups: $90 per group ($180 per week)
- Evening group: $60 per group

Cancellations and/or Group Absences

To provide the highest care to as many adults as possible, we have created the following agreement:

Group attendance is taken on a daily basis. We understand that people get sick and unforeseen circumstances arise. If this is the case, please call the Unity Community office direct line at **401-667-6783**. If we cannot get to the phone, please leave a message.

By signing below, I understand the above policies and procedures and authorize The Autism Project to bill me.

Signature: Date:

Printed Name:

ADULT PROGRAMMING APPLICATION

Adult Programing Group Pricing and 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 and Wednesday - $90 per group ($180 per week)
    Tuesday and Friday - $90 per group ($180 per week)
  - Evening group: Wednesday - $60 per group

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

PAYMENT OPTIONS:

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

☐ I would like to request a sliding scale scholarship application. Scholarships may be awarded on a sliding scale based on income. The sliding scale option is only for those who are funding Unity Community through self-pay.

*Contact Manisha Negi for more information at mnegi@brownhealth.org or 401-667-6797

☐ **BHDDH Self-directed plan funding**

Financial Payee Organization:

_____

Contact person and information at financial payee organization:

_____

Billing Address of financial payee organization:

_____

_____

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

Signature: Date:

- **Payment plans can be set up with Manisha Negi**.
  - Email: mnegi@brownhealth.org Phone: 401-667-6797

Demographic Survey

The information requested is for data purposes only. Please **do not** include your 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 ☐ Rett 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 ☐ Rett 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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