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

# Social Skills Group Application

**APPLICATION DEADLINE: SEPTEMBER 12, 2025**

**GROUPS WILL BEGIN THE WEEK OF OCTOBER 13TH**

**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 | | | |
| **Preferred Language:** | **Translator needed?** ☐ Yes ☐ No | | |
| **Cell # to enroll in text alerts:** | | | |
| **Please list any group(s) your child previously attended with us:** | | | |

**WHAT TYPES OF GROUPS WOULD YOU LIKE YOUR CHILD TO PARTICIPATE IN?**

Foundational Group Skills:

☐ Move & Groove ☐ Leaps & Bounds ☐ Skills for Life ☐ Let's Talk (AAC facilitation group)

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

**Are there any restrictions regarding days of the week/availability?** *Please note below:*

# Social Skills Group Application

**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#:** |
| **Additional Pickup Contact Name:** | | |
| **Relationship:** | **Home#:** | **Cell#:** |
| **Names of Parents:** | | |

| | |
|---|---|
| **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

School Name: _____

**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)**

_____

_____

_____

# Social Skills Group Application

**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 |

# Social Skills Group Application

**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:**

_____

_____

_____

_____

_____

**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.*<br>Signature of parent/guardian: Date: |
| Printed name of parent/guardian: |

# Social Skills Group Application

Lifespan ☒ Interview ☒ Video ☒ Photography ☒ Broadcast

Date: 2025-26

**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

**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. I agree to participate in the development of my or my child's/ward's treatment plan and consent to the services outlined in it.

*By signing below, I consent to services, as described above.*

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 $46.66 per week, if one-to-one support is required, an additional fee of $66.60 will be charged (total charge is $113.26). 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.
-We understand children get sick and unforeseen circumstances arise; however, if there are 3 or more episodes of late cancellation and/or group absences, we may choose to discontinue treatment for the remainder of the session.
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 our front desk at 785-2666 ext. 76784 OR AutismProjectGroups@brownhealth.org.

*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

## 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: |

# Social Skills Group Application

## Demographic Survey

The information requested is for data purposes only. Do not include name. We use this information as a nonprofit to apply and answer for grants and federal/state funding that requires demographic information.

**How does participant identify?** male female non-binary other

**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:** American Indian/Alaska Native African American/Black White/Caucasian
Native Hawaiian/Other Pacific Islander Asian Multi-racial
prefer not to answer

**Ethnicity:** 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:** Autism Spectrum Disorder Anxiety ADHD Depression Down Syndrome
Developmental Disability Intellectual Disability Other _____

**Preferred Language spoken in your home:**
English Spanish Portuguese Arabic Creole Swahili Hindi Mandarin
Other: _____

# Social Skills Group Application

**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 ($46.66 per week +$66.60 for 1:1 support if applicable)**

☐ 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