



# ADULT PROGRAMMING APPLICATION

Office Use Only	
Client#	_____
<input type="checkbox"/> New	<input type="checkbox"/> Ret.
<input type="checkbox"/> M	<input type="checkbox"/> NHP <input type="checkbox"/> UHC <input type="checkbox"/> SP
Amt.	<input type="text"/> chk # _____

## ADULT'S PERSONAL INFORMATION

<b>Name:</b>		Pronouns:	
Date of Birth:	Age:	Gender:	
Address:	City:	State:	Zip:
Phone Number:	Email:		
My adult is their own legal guardian <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>ICD-10 Diagnosis:</b> <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Other:			
_____			
Please FAX the <i>ICD-10 Medical Diagnosis Code</i> physician's form to The Autism Project at 401-785-2272 to confirm your adult's diagnosis. Please see the attached form on the second to last page of the application.			

## PARENT/GUARDIAN INFORMATION

<b>Parent/Guardian #1 Name:</b>		Relationship:	
I am my adult's legal guardian <input type="checkbox"/> Yes <input type="checkbox"/> No			
Address:	City:	State:	Zip:
E-mail:	Home #:	Cell #:	
<b>How do you prefer The Autism Project contact you?</b> <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail to home address			
Preferred language:		Translator needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____			
<b>Parent/Guardian #2 Name:</b>		Relationship:	
I am my adult's legal guardian <input type="checkbox"/> Yes <input type="checkbox"/> No			
Address:	City:	State:	Zip:
E-mail:	Home #:	Cell #:	
Preferred language:		Translator needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>How do you prefer The Autism Project contact you?</b> <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail to home address			
<b>Please indicate the primary contact person</b> <input type="checkbox"/> Parent/Guardian #1 <input type="checkbox"/> Parent/Guardian #2 <input type="checkbox"/> Both			

<b>Emergency Contact #1 Name:</b>		
Relationship:	Home #:	Cell #:
<b>Emergency Contact #2 Name:</b>		
Relationship:	Home #:	Cell #:



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## MEDICAL INFORMATION

Please attach a recent photograph of yourself here.



<b>Physician's Name:</b>	<b>Phone #:</b>
<b>Current Medications</b> (if any): _____ _____	
<b>Allergies</b> (if any): _____ _____	
<b>Food Restrictions</b> (if any): _____	
<b>Seizures:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe. What is the protocol? _____	
<b>Physical limitations</b> (if any): _____	
<b>Other information you would like us to know:</b> _____ _____	
<i>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.</i>	
<b>Signature:</b>	<b>Date:</b>



# 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: \_\_\_\_\_

Private: \_\_\_\_\_

Home School

College/University: \_\_\_\_\_

Other: \_\_\_\_\_

**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 to 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 a ride from someone: \_\_\_\_\_     Takes RIDE/RIPTA: \_\_\_\_\_

No



## ADULT PROGRAMMING APPLICATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### My adult lives...

- Independently     With parents     With roommates     In a group home     In a SLA  
 Other: \_\_\_\_\_

### INTERESTS:

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

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

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### Leisure and Recreation:

What are some activities that your adult participates in for leisure or recreation?

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## ADULT PROGRAMMING APPLICATION

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Visual Schedules  | <input type="checkbox"/> Chewing Gum          | <input type="checkbox"/> Fidgets            |
| <input type="checkbox"/> First/Then Boards | <input type="checkbox"/> Headphones           | <input type="checkbox"/> Joint compressions |
| <input type="checkbox"/> Social Stories    | <input type="checkbox"/> Relaxation Protocols |   |
| <input type="checkbox"/> Work Systems      | <input type="checkbox"/> Weighted Materials   |   |
| <input type="checkbox"/> Chewies           |   |   |
| <input type="checkbox"/> Other: _____      |   |   |

### 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: \_\_\_\_\_

## ADULT PROGRAMMING APPLICATION

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: \_\_\_\_\_



# ADULT PROGRAMMING APPLICATION

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

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# ADULT PROGRAMMING APPLICATION

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

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

- |   |  |
|---|--|
| <input type="checkbox"/> Dressing             | <input type="checkbox"/> Transportation    |
| <input type="checkbox"/> Bathing              | <input type="checkbox"/> Shopping          |
| <input type="checkbox"/> Eating               | <input type="checkbox"/> Daily chores      |
| <input type="checkbox"/> Ambulating (walking) | <input type="checkbox"/> Money management  |
| <input type="checkbox"/> Toileting            | <input type="checkbox"/> Food preparation  |
| <input type="checkbox"/> Personal hygiene     | <input type="checkbox"/> Telephone use     |
| <input type="checkbox"/> Taking medication    | <input type="checkbox"/> 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.**

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**Has your adult ever participated in social skills groups or camp at The Autism Project before? If yes, please list them below:**

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# 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 completed 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, confirm funding, and participate in an intake meeting before starting the Unity Community program.*

Signature of parent/guardian:

Date:

Printed name of parent/guardian:



# ADULT PROGRAMMING APPLICATION

## AGREEMENT TO PAYMENT & ATTENDANCE

### Authorization for Payment

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

- Day time groups: \$90 per group (\$180 per week) – meets twice per week
- Evening group: \$67.50 per group -- meets once per week

### 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** or reach out to your group facilitator through the **Remind app**, or email **Lauren.stumper@brownhealth.org**. If we cannot get to the office phone, please leave a message.

The Autism Project follows the Johnston Public Schools' inclement weather closures. Groups will be cancelled when Johnston Public Schools are cancelled or virtual due to weather. You will be notified via email and the Remind app and email if The Autism Project is closed and groups are cancelled.

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

Signature:

Date:

Printed Name:

## EMERGENCY PROTOCOLS

In case of an emergency, I understand that every effort will be made to contact me, or the emergency contacts 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.

*By signing below, I understand the above policies and procedures and authorize The Autism Project to use their standard protocol to maintain the safety of my adult.*

Signature of parent/guardian:

Date:

Printed name of parent/guardian:



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## 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 - \$67.50 per group

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

### PAYMENT OPTIONS:

<input type="checkbox"/> <b>Self-Pay</b> *Invoices will be mailed to your home address with the total amount due for the session.
<input type="checkbox"/> 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 <a href="mailto:mnegi@brownhealth.org">mnegi@brownhealth.org</a> or 401-667-6797
<input type="checkbox"/> <b>BHDDH Self-directed plan funding</b> Financial Payee Organization (e.g. Perspectives, Trudeau, Seven Hills, etc.): _____ Contact person and information at financial payee organization: _____ Billing Address of financial payee organization: _____ _____
<b><i>I authorize The Autism Project to process my payment as indicated above.</i></b>  Signature: _____ Date: _____

- ✚ **Payment plans will be set up with Manisha Negi.**
  - Email: [mnegi@brownhealth.org](mailto:mnegi@brownhealth.org) Phone: 401-667-6797



## ADULT PROGRAMMING APPLICATION

### 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.

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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:



# ADULT PROGRAMMING APPLICATION

## Demographic Survey

The information requested is for data purposes only. Please **do not** include your name on this form.

**Member's Sex**     male     female     other     prefer not to answer

**Member'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<sup>a</sup>     Not Hispanic or Latino or Spanish Origin     prefer not to answer

<sup>a</sup> 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     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 \_\_\_\_\_

**Secondary Diagnosis**     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