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:		
I prefer you contact me through: ☐ Phone ☐ Email			
I am my own legal guardian ☐Yes ☐ No			
ICD-10 Diagnosis: ☐ Autism Spectrum Disorder ☐ Other: _____			
Please FAX the *ICD-10 Medical Diagnosis Code* physician's form to The Autism Project at 401-785-2272 to confirm your diagnosis. Please see the attached form at the back of this second to last page of this application.			

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 Name:		Relationship:	
This parent/guardian is my legal guardian ☐ Yes ☐ No			
Address:	City:	State:	Zip:
E-mail:	Home #:	Cell #:	
How do you prefer The Autism Project contact you? ☐ Phone ☐ Email ☐ Mail to home address			
Preferred language:		Translator needed? ☐ Yes ☐ No	
Parent/Guardian #2 Name:		Relationship:	
This parent/guardian is my legal guardian ☐ Yes ☐ No			
Address:	City:	State:	**Zip:**
E-mail:	Home #:	Cell #:	
Preferred language:	Translator needed? ☐ Yes ☐ No		
Preferred way to contact parents/guardians? ☐ Phone ☐ Email ☐ Mail to 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 #:

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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 If Yes, please describe. What is the protocol?	
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:**

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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: _____

☐ Private: _____

☐ Home School

☐ College/University: _____

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 your program/community?

☐ Yes

☐ No

If **yes**, do you have support staff to accompany you to Unity Community?

☐ Yes

☐ No

Do you receive support funded by BHDDH?

☐ Yes ISP plan date: _____

☐ No

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

☐ Yes I drive myself: _____ I get a ride from someone: _____ I take RIDE/RIPTA: _____

☐ No

I live…

☐ Independently ☐ With my parents ☐ With roommates ☐ In a group home ☐ In a SLA

☐ Other: _____

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Name: _____ Date: _____

INTERESTS:

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.)

_____

_____

_____

LEISURE AND RECREATION:

What are some activities that you participate in for leisure or recreation?

_____

_____

_____

Do you 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

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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 indicate my likes and dislikes
- ☐ I follow multi-step directions
- ☐ I make requests for my basic wants and needs

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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)
- ☐ 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 anxious, 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:

_____

_____

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Name: _____ **Date:** _____

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

I may *NOT* be independent in the following areas yet:

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

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

_____

_____

_____

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.

_____

_____

_____

_____

_____

_____

Have you 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: Date:

Printed name:

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) – 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, every effort will be made to contact the emergency contacts you have listed. If they cannot be reached, I understand that staff will use a standard 911 protocol and have you 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 my safety. Signature: Date:
Printed name:

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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

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 (e.g. Perspectives, Trudeau, Seven Hills, etc.):
_____

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

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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 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:

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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[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 ☐ 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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