



## Social Skills Groups Registration Cover Page

Participant's Name:		DOB:	Age:	School Grade:
Name(s) of Parent(s)/Caregiver(s):				
Address:		City:	State:	Zip:
Phone 1:		Phone 2:	Email:	
Diagnoses:				Diagnosis date:
<input type="checkbox"/> New <input type="checkbox"/> Returning: List groups & years attended:				
<p><b>Programs covered by RI Medicaid (Rite Care/Katie Beckett) A self-pay \$15.00 registration fee is required with this application.</b> Total = \$15.00 if applying for multiple programs. If you do not have Medicaid please contact Sue at 785-2666, ext. 1005 or visit <a href="http://theautismproject.org">theautismproject.org</a> for program costs.</p>				
<input type="checkbox"/> Creative Expressions (E. Greenwich)*		<input type="checkbox"/> Game On! (Johnston & Warwick)*		<b>New Groups:</b>
<input type="checkbox"/> Take a Bite!		<input type="checkbox"/> Leaps & Bounds		<input type="checkbox"/> In Harmony: Music Rocks (music-based activities)
<input type="checkbox"/> Club Jr. (field trips)		<input type="checkbox"/> Social Thinking		<input type="checkbox"/> Curtain Call (drama-based activities)
<input type="checkbox"/> Club Jr.-L.S. (field trips)		<input type="checkbox"/> Move & Groove		<input type="checkbox"/> Teen Talk
<input type="checkbox"/> The Club (field trips)		<input type="checkbox"/> Girls Night Out (self-pay fee for each activity)		
<input type="checkbox"/> Middletown site is requested if available				
<p><b>Total # of groups you wish to attend ____.</b> Please <u>number</u> your top 3 choices to help with placement.</p> <p>* <b>Pre-requisite:</b> Groups that meet off-site require prior approval from Project staff for participation. Separate Adult Application is available for the Adult Community Group and the Breakfast Club.</p>				
<p><i>Please complete the following information in the event that an emergency arises and we must contact you. Include information about how to reach you or another designated person during your child's group.</i></p>				
<b>Emergency Contact Name</b>		<b>Relationship</b>		<b>Phone Number(s)</b>
<b>Emergency Medical Information</b>				
Name of Physician:		City:	Phone:	
Please check all items that apply to child's present health. Thoroughly explain any checked answers.				
Allergies (list below):		<input type="checkbox"/> No known allergies		
<input type="checkbox"/> Food (include any dietary restrictions):				
<input type="checkbox"/> Insects/Plants:				
<input type="checkbox"/> Medicine Allergies:				
Treatment for any of the above that The Autism Project may need to do:				
Medications my child is taking:				
<i>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.</i>				
Signature of parent/guardian:			Printed name:	Date:
CEDARR? <input type="checkbox"/> yes <input type="checkbox"/> no		Agency:	HBTS? <input type="checkbox"/> yes <input type="checkbox"/> no    Agency:	

Office Only: U-A-session \_\_\_\_\_ / \_\_\_\_\_ RE TPR TC SC SB ENR 25-100% \_\_\_\_\_



## The Autism Project Social Skills Program PARTICIPANT PROFILE

Participant's Name	DOB	Date		
Please complete the following sections and provide as much detail as possible. This information will help us create a successful group experience for your child. Please indicate your child's abilities in each of the following areas:				
Child's Likes: <i>top 4</i>	Child's Dislikes: <i>top 4</i>			
(favorite movies, characters, foods, games, music...etc) (sounds, smells, touch, movement, foods etc...)				
<b>Does your child use any of the following?</b>				
<input type="checkbox"/> Visual schedules	<input type="checkbox"/> Social Stories	<input type="checkbox"/> Conversation Scripts		
<input type="checkbox"/> Choice Zone Worksheet	<input type="checkbox"/> Problem Solving Worksheets	<input type="checkbox"/> Contingency Mapping		
<input type="checkbox"/> Headphones	<input type="checkbox"/> Brushing Protocol	<input type="checkbox"/> Thera-tubing/Chewy		
<input type="checkbox"/> Chewing Gum	<input type="checkbox"/> Weighted Blanket/Vest	<input type="checkbox"/> Joint Compressions		
<input type="checkbox"/> Relaxation Protocols	<input type="checkbox"/> Fidgets: _____			
<input type="checkbox"/> Sensory Diet <i>If yes please indicate-</i>				
<input type="checkbox"/> Other:				
<b>Please describe your child's toileting</b>				
	Complete Assistance	Partial Assistance	Independent	Comments:
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Stress Response:</b> How does your child usually indicate he/she is becoming anxious or stressed?				
<i>Please check all that apply and add details as needed</i>				
<input type="checkbox"/> Ask inappropriate questions/Makes inappropriate comments	<input type="checkbox"/> Runs away			
<input type="checkbox"/> Leaves room/chair	<input type="checkbox"/> Touches other inappropriately			
<input type="checkbox"/> Becomes off task	<input type="checkbox"/> Scratches, bites, hits self			
<input type="checkbox"/> Meltdown	<input type="checkbox"/> Scratches, bites or hits others			
<input type="checkbox"/> Becomes Silly	<input type="checkbox"/> Screams			
<input type="checkbox"/> Noises/humming increases	<input type="checkbox"/> Shuts down			
<input type="checkbox"/> Cries/Tearful	<input type="checkbox"/> Other:			
<input type="checkbox"/> Voice tone/volume changes				
What is helpful in calming these actions?				

Participant Name:

Date:

<b>EMOTIONAL DEVELOPMENT *if YES, list <i>how</i> and <i>what</i> works best to accomplish task</b>		
<b>Does your child:</b>	<b>Yes/No</b>	<b>Comments</b>
Request a break when upset?		
Express feelings?		
Indicate relaxation?		
Request assistance?		
Indicate likes/dislikes?		
Express confusion ("I don't know")		
<b>SOCIAL DEVELOPMENT</b>		
<b>Does your child:</b>	<b>Yes/No</b>	<b>Comments</b>
Engage in solitary play?		
Play same toy along side peers?		
Engage in group play?		
Share materials?		
Turn take with peers?		
<b>COMMUNICATION What is your child's preferred means of communication?</b>		
<b>Does your child:</b>	<b>Yes/No</b>	<b>Comments</b>
Follow non-verbal directions? (ie. Picture schedule)		
Follow verbal directions within familiar routines?		
Follow verbal directions within new activities?		
Utilize visual supports to follow directions? If yes what		
Require processing time to follow directions?		
Make requests for basic wants and needs?		
Comment on environment or the unexpected (oops!)?		
Converse with peers/ adults?		

Participant Name:

Date:

<b>ORGANIZATION &amp; TRANSITION</b>		
<b>Does your child:</b>	<b>Yes/No</b>	<b>Comments</b>
Make transitions?		
Recognize personal belongings?		
Organize needed materials for outings?		
Make choices?		
Wait when directed?		
<b>COMMUNITY SKILLS</b>		
<b>Does your child go to:</b>	<b>Yes/No</b>	<b>Challenging/Positive Behaviors</b>
Grocery Store		
Fast Food Restaurant		
Sit Down Restaurant		
Movies		
Organized Sports		

Adapted from Kathleen Ann Quill's Assessment of Social and Communication Skills for Children with Autism

<b>Rate participant's behaviors from 1-5 (1-Never;2-almost never;3-sometimes;4-almost always;5-always)</b>			
	<b>Home</b>	<b>School/Community</b>	<b>Comments</b>
Listens to others			
Have triggers/anxiety/fear			
Demonstrates Problem solving			
Able to read cues/directions			
Accepts responsibility for actions			
Understands others' feelings			
Stays on topic			
Group participation			
Understands humor			
Uses facial expressions			
Asks for assistance when needed			
Regulates own behaviors/emotions			
Comprehends rules/expectations			
Converses with unfamiliar adults			
Argues with authority figures			
Please add any additional comments you feel staff should know and areas of concern or specific skills you are looking for us to be helpful in teaching your child.			
<b>Reviewed by Autism Project Program Coordinator:</b>			<b>Date:</b>



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

Dear Participant,

This is a survey we need you to complete once every year in order to report statistical and demographic information for a United Way grant that supports this program and to fulfill data requirements for future grant opportunities. Please take a few minutes to fill out the survey below. No names are required and all information will be kept strictly confidential. Thank You!

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## Direct Service Programs Demographic Survey

### Participant's Information

Sex of participant  Male  Female      Participant's Age: \_\_\_\_\_

Participant's Primary Language  English  Spanish  Portuguese  Non-verbal

### Primary Diagnosis

Autism       Asperger Syndrome       Childhood Disintegrative Disorder  
 High Functioning Autism       Fragile X       Retts Syndrome Disorder  
 PDD-NOS       Non-Verbal Learning Disorder

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### Family's Information

Number of people living in the household \_\_\_\_\_

0-20,000       10,000-25,000       26,000-50,000       51,000+

### Nationality

African       African American/Black       Asian       Asian American/Pacific Islander  
 Cape Verdean       Caribbean       Caucasian/White (non-Hispanic)  
 Hispanic/Latino       Native American       Portuguese       Multi-Racial/Multi-

Ethnic

Other (please specify): \_\_\_\_\_       Information Not Available



## Social Skills Program

### PAYMENT INFORMATION

<b>Participant Name:</b>	
<b>Parent Name:</b>	
<b>Billing Address:</b>	
<b>City:</b>	<b>State:</b>
<b>Zip:</b>	
<b>Method of payment for Registration Fee</b> <input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover RI Medicaid/Katie Beckett does <i>not</i> cover the \$15.00 registration fee that is required with this application.	
For Credit cards, Card #	Exp. Date:
Cardholder's Name:	
Cardholder's Billing Address:	
<b>Method of payment for Program Fee</b> <input type="checkbox"/> RI Medicaid/Katie Beckett ( <u>please include copy of card</u> ) <input type="checkbox"/> Self-pay (check website for prices) <input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Visa/MasterCard/Discover	
For Credit cards, Card #	Exp. Date:
Cardholder's Name:	
Cardholder's Address:	
<i>I authorize The Autism Project to process my payment as indicated above.</i>	
Parent/Guardian Signature:	Date:

<b>FOR OFFICE USE ONLY</b>	
Payment Received: ___ / ___ / ___ \$_____	Initials:___ Katie Beckett Approved: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a



## Social Skills / Camp Programs AGREEMENT FOR ATTENDANCE AND PAYMENT

Child:	DOB:
Address:	SS#:
<p><b>Authorization for Payment:</b>          The Autism Project provides social skills groups and specialized treatment for children through an established fee structure. We will pursue reimbursement for services through one of the following sources, as designated by you:</p> <p><input type="checkbox"/> Medicaid (through RItCare, Katie Beckett, SSI, or adoption subsidy)</p> <p><input type="checkbox"/> Self-pay; Cost of session = \$ _____, to be paid on or before: _____</p> <p><input type="checkbox"/> Commercial insurance: Plan Name: _____          Insurance Number: _____</p>	
<p><b>Cancellations:</b>          Our programs rely heavily on planning for your child's participation. Attendance is crucial to sustain program existence. Cancellations must be made within 24 hours prior to a scheduled group. To report an absence, please call the office at 785-2666 with the date, child's name, and the group your child attends. After two absences, program participation will be reviewed and may result in loss of placement for that session.</p>	
<p><b>Registration:</b>          Parents/Caregivers must apply for each group session. Registration for a previous group session does not guarantee a placement in the next group session. A full application must be completed each year; an abbreviated application may be submitted for subsequent sessions.</p>	
<p><b>Grouping:</b>          Groups are formed based on the applicants' ages and ability levels. You will be contacted about your child's placement in group. Because the goal is to learn new skills, groupings take into consideration children's age, ability, and specific environment in which the child will have the most success. Whenever possible, we will try to accommodate your group preferences.</p>	
<p><i>I understand the above policies and procedures and authorize The Autism Project to bill Medicaid, me, or my insurance company as designated for payment.</i></p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	

Please complete this form if you have CEDARR Services so we may coordinate your child's services. Thank you.



**Release of Information Form**

Client Name:	Date of Birth:		
I authorize the Autism Project to (check all that apply):			
<input type="checkbox"/> Release to <input type="checkbox"/> Discuss with <input type="checkbox"/> Obtain from			
Name of CEDARR Family Center:			
Contact Person:	Phone #		
Street	City	State	Zip Code
Name of CEDARR Direct Service Provider:			
<input type="checkbox"/> HBTS <input type="checkbox"/> PASS <input type="checkbox"/> KidsConnect <input type="checkbox"/> Respite			
Contact Person:	Phone #		
Street	City	State	Zip Code
<p>This release is for the purpose of coordinating services for my child, and includes my child's Family Service Plan and any/all service Treatment Plans.</p> <p>This authorization is valid for one year commencing on the date of my signature. Medical/health information is protected under Rhode Island Law 78H-7522. Information released with this authorization will not be given, sold, transferred or in any way relayed to any other person not specified in the consent form. The consent for release or transfer of information may be withdrawn at any future time.</p>			
Parent/Guardian Signature			Date



## Social Skills / Camp Programs PERMISSION TO PHOTOGRAPH

Participant:	DOB:
<p>Thank you for your interest in the Autism Project's social skills program. We are always striving to provide the best in innovative and meaningful programs designed for children with autism spectrum disorders, and to provide the highest quality support and education for parents and professionals. In this spirit, we are pleased to be able to be a training site for students and professionals throughout our community.</p> <p>To ensure a productive and enjoyable experience for both students and educators, we are adopting an OPEN PICTURES POLICY. Children attending groups and camp may have their pictures taken throughout the day. In addition to using photos and videos for training purposes, please be advised that photos may be used for program development and marketing purposes, including but not limited to newspaper articles, television promotion, brochures, and other Autism Project advertising vehicles.</p> <p>Thank you for your cooperation with this policy and willingness to share your child's experiences. Please sign below.</p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	



## Social Skills / Camp Programs PERMISSION FOR RESTRICTIVE PROCEDURES

Participant:	DOB:
<p>The Autism Project uses evidenced-based strategies that are designed to establish a supportive and safe environment that will prevent your child from having behavioral difficulties. However, there may be rare occasions when the physical safety of the child, other participants, and staff is at risk. When this type of incident occurs it may be necessary to physically hold your child to prevent harm, and to help her/him feel safe. Trained staff will only use a therapeutic hold in which your child is seated in a chair or on the floor and held in a "wrap" from behind. The hold is only maintained for as long as it takes for your child to begin to regain emotional and physical control so that s/he can move to a quieter area until they are able to rejoin the group. If it is necessary to move your child to a safe area before s/he has regained control, two staff will use an approved escort procedure. These procedures are carried out in a calming, supportive, and non-punitive manner. You will be notified when you pick up your child of the intervention so that you can assist staff in processing the incident and supporting your child.</p>	
<p><i>I understand that the above procedures will be implemented only for the purpose of safety and control and in accordance with the stated guidelines. I authorize that the seated wrap or two person escort will not compromise the medical safety of my child.</i></p>	
Signature of parent/guardian:	Date:
Printed name of parent/guardian:	



## Social Skills Program PERMISSION TO PICK UP CHILD

Child:	DOB:		
Parent:	Date:		
Address:	Phone:		
<p>Please complete the following information in the event that someone other than yourself may pick up your child from a social skills group. You must notify us in advance of who will be picking up your child. Please note that we may ask that person to present identification to verify their identity before releasing your child to her/him</p>			
Name	Address	Relationship	Phone #
Signature of parent/guardian:			Date:
Printed name of parent/guardian:			