Confidence Connection Summer Program-2016

Please complete and return to:

Confidence Connection
Attention: Eve Weber, Director of Services
140 Gould Street
Needham, MA 02494

Summer Program Dates: June 27th-August 19th

Check all that apply: (TWO WEEK MINIMUM)

____Week One: (6/27-7/1)
____Week Two: (7/5-7/8)
____Week Three: (7/11-7/15)
____Week Four: (7/18-7/22)
____Week Five: (7/25-7/29)
____Week Six: (8/1-8/5)
____Week Seven: (8/8-8/12)
____Week Eight: (8/15-8/19)

GENERAL INFORMATION (Please note this information is required/needed for insurance coverage as well as for us to get to know your child)

Child Name:	**Parent(s) Name:**
Age/DOB:	**Diagnosis:**
Child's Address:	
Emergency Contact (Name, Phone, Relationship to Client) **Other than parent	
Allergies/Diet/Preferences: (Confidence Connection is a peanut free environment ☺)	

Background Information

A. General background history

Mother's Name:	
Profession:	
Cell Number:	

Home Number:	
Email:	
Address: (if same as child right same)	

Father's Name:	
Profession:	
Cell Number:	
Home Number	
Email:	
Address: (if same as child right same)	

List family members (siblings, other(s) living with child):

Name/ Relationship to Child	Age	Gender	Lives at home (Y/N)

Are you interested in enrolling a typical "peer model" (sibling, friend, etc): Circle one YES NO

B. Other pertinent background history

- Race (optional): African American Asian Hispanic White/Caucasian Other: _____
- Parents are currently: □Married □Separated □Divorced □Remarried □Other
- Languages spoken other than English:
- Child's main language:

C. Medical History:

PRIMARY PHYSICIAN
Name:
Address:
Phone: Fax:
NPI Number:

1. Hospitalizations: _____

_____

2. Chronic illnesses (asthma, diabetes, allergies, etc.) and treatment: _____

_____

3. Other illnesses and treatments: _____

_____

4. Family History of Mental Health or Developmental Disorders: _____

_____

5. Has your child had a full diagnostic evaluation (neuropsych, etc): _____ Yes _____ No *If yes, please attach.

D: History of past and present medications (do not include regular antibiotics for colds, etc.)

Medicine	Indication	Dosage	Duration of Treatment	Side Effects

E. School/Educational Information

Current School (Name): _____

Services in School: _____

School Hours: _____

Does your child have an IEP at school? No _____ Yes (If yes, please attach a copy) _____

Services/Providers outside of school/duration: _____No _____ Yes, Type of Service: _____

If yes, what is the name of your child's other treatment provider? _____

Address: _____ Phone: _____

May we contact your child's other treatment provider in order to coordinate care? ____Yes ____No

H. Social Life:

What kind of activities does your child do with her/his friends?_____

_____

What does your child do for fun? (activities, hobbies, sports, etc.)

_____

_____

What community resources, if any, are currently being utilized by the child or family? _____

_____

STUDENT SYMPTOM PROFILE

Describe your child's social language skills:

Describe your child's educational programming (Please attach IEP):

Behavior: *Please describe if your child exhibits any of the following problem behaviors on a consistent basis: (please note: a child's application will not be rejected based on behavioral symptoms).*

□Hits □Kicks □Bites □Scratches □Pinches □Tantrums □Yells

□Other _____

Does your child have a behavior plan at school? _____ YES _____ NO (If yes, please attach a copy)

GETTING TO KNOW YOUR CHILD

Please check the box for the social skills that your child has MASTERED:

- □ Independent Play Skills- does at least 5 different activities with at least 5 different toys (plays with most toys appropriately)
- □ Independently plays with toys and engages in verbal behavior (with himself)
- □ Independently plays with toys and engages in verbal behavior (with a peer)
- □ Cooperative Play/Small Group Play
- □ Participates in group activities with out prompts
- □ Attends to teacher and other students in a group of 4-5 kids
- □ Follows daily routines (i.e. hanging up his coat without prompts)
- □ Waits appropriately for his turn
- □ Requests items from adults AND peers (hundreds of times a day)
- □ Takes turns
- □ Shares toys
- □ Searches for missing peers
- □ Plays interactively with students (more than 8 different peers)
- □ Pretend Play
- □ Imitates peers
- □ Initiates and returns greetings
- □ Eye contact
- □ Follows directions from a peer
- □ Commenting about what he sees/does
- □ Initiating Conversations
- □ Monitoring Conversations (identifying when a child is not listening or bored)
- □ Maintaining Conversation
- □ Disengaging from Conversation (ending a conversation)
- □ Joining a conversation already in progress
- □ Recognizing the signs that someone is busy – not interrupting
- □ Taking the other person's perspective

- Flexibility
- Reading nonverbal cues

Goals
What are *your* goals for your child this summer?

1. _____

2. _____

3. _____

What are your child's favorite areas of interest?

Emergency Permission to Treat Medically

In the event of an emergency, I give my permission for the staff of Confidence Connection to treat my child and/or release information to appropriate medical staff regarding my child.

_____ _____
Parent / Guardian's Signature Date

Valuables

Confidence Connection is not responsibility for your child's personal property. Please do not permit your child to bring in valuable or personally significant items. I understand this policy and will not hold Confidence Connection or its employees liable for any lost property.

_____ _____
Parent / Guardian's Signature Date

Late Pick-up

I understand that I am to pick-up my child on time each day and that I may be charged a $1 per minute per minute fee if I am more than five minute late.

_____ _____
Parent / Guardian's Signature Date

Photograph Release

Confidence Connection often uses photographs and videotape to help children learn more appropriate social skills, to communicate information to families, and to help people understand more about our summer program.

I authorize Confidence Connection to use photographs / videotape for the above purposes.

_____ _____
Parent / Guardian's Signature Date

Admission to Program

I understand that my child is not approved for admission until I receive notification of acceptance and my deposit has cleared or have insurance authorization. I understand that unless Confidence Connection has worked with my child within the past year, Confidence Connection will need to evaluate my child prior to admission in order to find him/her an appropriate group placement.

_____ _____
Parent / Guardian's Signature Date

TRANSPORTATION

My child is being transported to camp via:

_____ Child's own parents/carpool/ babysitter _____ School Transportation

_____ Unclear as of today

Name: _____

Phone Number: _____

Address: _____

Relationship to the Child: _____

*****If the school is transporting your child please have them fill out information below:

Name of Company_____

Company's Address: _____

Town, State, Zip: _____

Phone: _____

Transportation Release

Besides the bus company, Confidence Connection will only release your child to people listed on the previous page. Anyone who is not your child's parents will be required to show photo ID to pick up your child. If your child is going home with another child one day, please call ahead or speak directly to your child's lead therapist on the day of the transportation change.

FINANCING

The cost of summer program is $650 week. In order to hold a spot for your child, the person guaranteeing payment should fill out this form and return it to Confidence Connection with a deposit of **one week's fee; if your insurance does not cover ABA services**. The balance of fees will be due NO LATER THAN JUNE 1, 2015. If your town/school system is financing your child's summer program we must have a purchase order attached to the application. For insurance coverage please attach a copy of your insurance card and fill out the insurance form. Confidence Connection accepts, Harvard Pilgrim, Blue Cross Blue Shield, Tufts, Cigna and Aetna. Confidence Connection also accepts checks, flexible spending and credit cards (Visa, MasterCard, Discover). Please make checks payable to Confidence Connection.

If, for any reasons, you need to cancel your space and you have placed a deposit, refunds are giving according to the following terms:

- If cancellation is before July 1, 2016: 100% of your money will be refunded
- We will not be able to refund tuition when cancellation are made after July 1, 2016

Should my child be accepted to the Confidence Connection summer program, by signing below, I agree to the above terms of summer financing and understand that I am ultimately responsible for all fees unless the school/agency completes this form listed below.

_____

Parent / Guardian's Signature Date

Photograph

Place a photo of your child here. This photo will be used for social stories, attendance charts, etc to help your child during social skills lessons.

Confidence Connection Insurance Registration Form

Child's Name (Last, First, Middle): _____

Date of Birth: _____/_____/_____ Sex: M / F Social Security Number: _____-_____-_____

Street Address :_____City:_____ State: _____Zip Code: _____

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

Mother's Name (Last, First): _____ Date of Birth: _____/_____/_____

Father's Name (Last, First): _____ Date of Birth: _____/_____/_____

Insurance Information

Primary Insurance: _____ Insurance ID: _____ Co-payment: $_____

Primary Insurance Phone: (_____) _____-_____ Effective Date: _____/_____/_____

Policy Holder's Name: _____Policy Holder's Date of Birth: _____/__ ____/_____

Policy Holder's Social Security Number: _____-_____-_____ Relationship to Patient: _____

Insured Employer: _____ Sex: M / F

Other insurance provider: _____ Insurance ID:_____

Emergency Contact

Name (Last, First): _____Relationship: _____

Street Address :_____ City:_____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

I authorize the release of any medical information necessary to process bills to my insurance company and request payment of benefits to Confidence Connection. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand that I am responsible for providing continuous up-to-date information regarding my insurance coverage. I understand that I am responsible for paying the required co-payment and deductibles that arise during the course of treatment as mandated by my insurance. I agree to leave a credit card on file so that co-pays and deductibles can be paid in a timely manner.

Signature: _____ Date: _____/_____/_____

SUMMER PROGRAM APPLICATION 2016 CHECKLIST

Dear Families,

Thank you for completing our summer program application. Below is a checklist of items that need to be complete in order for your child's application to be processed.

_____ You have **completed ALL sections of the application**

_____ You have **enclosed a copy of your child's records** (i.e., current IEP and most recent comprehensive evaluation(s) such as: psychology, neuro-psychology, medical, occupational therapy, speech therapy, school progress, etc.).

_____ You have **enclosed a recent photo** of your child

_____ You have **enclosed a deposit, copy of insurance card (both sides) or a purchase order from the school**

_____ You have completed **the insurance registration form.**

Once we have received your completed application, we will send you an email that we have received your application. If any Confidence Connection Team Leader has worked with your child over the past year, your child will not need to be screened. If we do not know your child, we may call to schedule an intake appointment and determine if your child will benefit from our summer program and where to place him/her. If you have any questions, please feel free to contact Confidence Connection at (781) 433-9890.

We look forward to a great summer!

The staff of Confidence Connection ☺