Confidence Connection Summer Program-2020

Please complete and return to:
Confidence Connection
Attention: Eve Weber, Director of Services
140 Gould Street
Needham, MA 02494

Summer Program Dates: June 29th-August 28th, 2020

Check all that apply: (FOUR WEEK MINIMUM)

____Week One: (6/29-7/3)
____Week Two: (7/6/-7/10)
____Week Three: (7/13-7/17)
____Week Four: (7/20-7/24)
____Week Five: (7/27-7/31)
____Week Six: (8/3-8/7)
____Week Seven: (8/10-8/14)
____Week Eight: (8/17-8/21)
____Week Nine: (8/24-8/28)

BACKGROUND INFORMATION

Client Name:	Diagnosis:
DOB:	Allergies/Special Diets:
Parent/Guardian Names:	Referred By:
Client Address:	
Emergency Contact/Relationship to Client (Not including parents/guardians):	

A. General background history

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

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

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

Name/ Relationship to Client	Age	Gender	Lives at home?

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:_____
- What do you consider your (your child's) main language? _____

C. Medical History:

PRIMARY PHYSICIAN
Name:
Address:
Phone: Fax:
May we contact your child's PCP in order to coordinate care?_____Yes____No For Office Use Only: If consent given, PCP contacted on: _____

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. List any behaviors that your child exhibits that can be considered risk behaviors which includes harm to self or others.

_____

6. Family medical issues that may affect treatment: _____

_____

D. Developmental History:

1. Relevant Information Regarding Pregnancy/Birth: _____

_____

2. Estimate when your child first:

Rolled over	_____	Sat up on own	_____		
Crawled	_____	Stood	_____	Walked	_____
Ran	_____	Said first word	_____	Said phrases	_____

3. Please check if your child has had any of the following (and if so, at what age):

____Seizures	____High fevers	____Measles	____Mumps
____Chicken Pox	____Whooping Cough	____Diphtheria	____Croup
____Pneumonia	____Tonsillitis	____Meningitis	____Encephalitis
____Rheumatic Fever	____Tuberculosis	____Sinusitis	____Chronic colds
____Enlarged glands	____Thyroid problems	____Asthma	____Chronic ear infections
____Heart trouble	____Head trauma	____Allergies (please describe):_____	

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

Medicine	Indication	Dosage	Duration of Treatment	Side Effects

F. Previous Therapeutic Treatments for Diagnosis (i.e. speech/OT, Floortime, etc) including dates:

G. School/Educational Information

Current School (Name): _____

Services in School: _____

Other 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? _____

I. Areas That May Impact Treatment:
1. Are there any spiritual, cultural or legal variables that may impact treatment?_____No_____Yes
If yes, what variables: _____
2) Are there any relevant legal issues that may impact treatment?_____No_____Yes

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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

Goals

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

1. _____

2. _____

3. _____

What are your child's favorite areas of interest?

What are your child's strengths?

What are areas that your child needs to work on?

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 minutes 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

Confidence Connection Social Summer Program is billed as group ABA (social group). If your insurance does not cover ABA 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, 2020. 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, 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 June 1, 2020: 100% of your money will be refunded
- We will not be able to refund tuition when cancellation are made after June 1, 2020

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:_____/_____/_____

ABA Service Agreement and Consent Form

This document contains important information about Confidence Connection (CC) applied behavior analysis (ABA) professional services and practice policies. It is important that you read through this information carefully and ask questions for clarification at any time. When you sign this document, it will represent an agreement between you and CC to provide ABA services. You, the consumer, reserve the right to withdraw at any time from these services. Again, please feel free to contact CC with any questions or concerns about CC's ABA Services at any time.

Services Offered

CC abides by the Behavior Analyst Certification Board Guidelines for Responsible Conduct

- Admission into ABA services will be available to children, adolescents, and adults with or without a diagnosis based on the need/desire to modify established behaviors. Certain provisions may apply in regard to diagnosis if someone is seeking funding for the service through a third party, such as private insurance or Medicaid.
- When needed, CC will provide the client/family with contact information for other professionals who may be better able to assist with the needs of the client if CC is unable to meet specific treatment needs.
- Services will focus on the development and implementation of a functional behavior assessment and an ABA treatment plan. ABA services will be provided by a Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCaBA) or a highly trained Behavior Specialist under the supervision of a BCBA.
- CC provides ABA services based on the client's current level of individualized needs. The treatment plan will structure antecedent and consequence-based strategies that are skill based, functionally equivalent, and non-aversive.
- Behavioral assessment results are available to the client and/or family, and a preliminary treatment plan meeting will be scheduled with the client and ABA professionals to review the proposed service type(s), treatment plan goals and objectives, recommended duration and length of treatment, and a discharge plan for the client.
- Upon discharge, recommendations will be provided as a way to support continued progress or address persisting concerns.
- The contents of both the assessment and treatment plan will be explained to the client and/or family, and CC staff will willingly answer any related questions about the assessment or proposed service. CC understands that this information is confidential, and will abide by established confidentiality policies and procedures.
- In addition to direct ABA treatment, ABA services also include training and ongoing consultation in the principles of applied behavior analysis as they pertain to the client's treatment plan with family, educators, and any related service providers.

Assessment, Preparation, and Participation

It is important for any individual to be able to perform at their best during an assessment. Please let the CC ABA office know of any illness or changes in medication or diet that may necessitate an assessment to be re-scheduled. Grafton believes in non-aversive, trauma-informed care using an integrated treatment approach to create a positive learning experience for any individual. Thus, CC also asks that our clients and/or families share information about an individual's preferences, dislikes, and needs that may arise during a clinical assessment. An initial assessment may be conducted in order to make recommendations, but the complete assessment process may take 15-20 total hours, or possibly longer, depending on the specific assessment procedures needed.

Additionally, parent/caregiver participation is an expectation of service. Participation may include team meeting, data collection, and implementation and involvement in the implementation of recommended strategies. If there is lack of involvement, CC reserves the right to reconsider the appropriateness of service. Team meetings will focus on progress monitoring, level of service needed, and barriers in treatment as a way to strive toward positive results.

Appointments

CC's ABA staff is committed to providing consistent, reliable service as scheduled and agreed upon by the client/family. CC proposes a preliminary set of hours for ABA services within the initial treatment plan, taking into consideration medical necessity (physician recommendation or prescription) and results of the behavioral assessment. Clients must follow CC's cancellation policy for services.

CC understands that circumstances, such as illness or family emergency, may arise which necessitate the occasional cancellation of appointments. To avoid any misunderstanding, CC's policy is for a client or family to contact the assigned behavior specialist/analyst directly to cancel or re-schedule session(s). Excessive cancellations by a client/family may result in termination of services, as consistency of the delivery of services as proposed in a treatment plan is critical. CC does ask that you attempt to give at least 12 hours of notice when canceling or rescheduling an appointment.

Communication

CC is committed to responding to any questions or comments regarding ABA Services in a timely manner. The Behavior Specialists, Behavior Analysts, and ABA Program Managers are committed to providing the best quality service to clients, which includes timely, professional communication. The clients will be provided with the telephone numbers and email addresses of those individuals involved in direct treatment service and planning. However, basic information about CC's ABA Services is available through our website (www.confidenceconnection.org). More detailed inquiries (non-case related) and referrals for ABA service should be directed to the ABA Program offices.

Consent

Your signature below indicates that you have received and read the information in this document. Consent by all parents/legal guardians is required prior to the implementation of ABA services.

These policies have been fully explained to me and I fully and freely give my consent for service to be implemented as proposed.

_____ _____

Client Date

_____ _____

Parent/Guardian (if applicable) Date

_____ _____

CC Representative Date

SUMMER PROGRAM APPLICATION 2019 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 ☺