



Confidence Connection Summer Program-2023

Please complete and return to:
Confidence Connection
Attention Michelle Cottrell
140 Gould Street
Needham, MA 02494

Summer Program Dates: June 26th through August 25th
Hours: Ages 3-5 years 8:30-12:00; Ages 6-16 years 1:00-4:15

Check all that apply: (SIX WEEK MINIMUM-DOES NOT NEED TO BE CONCURRENT)

| | |
|--|--|
| | Week One: 6/26-6/30 |
| | Week Two: 7/3-7/7 CLOSED 7/4/22 |
| | Week Three: 7/10-7/14 |
| | Week Four: 7/17-7/21 |
| | Week Five: 7/24-7/28 |
| | Week Six: 7/31-8/4 |
| | Week Seven: 8/7-8/11 |
| | Week Eight: 8/14-8/18 |
| | Week Nine: 8/21-8/25 |

***Speech and Language Therapy** is also available for kids two years of age through adolescents. We offer comprehensive evaluations and treatments designed to increase skills for learning, language, communication, and cognitive skills. We accept the following insurances for speech: BCBS and HPHC

Please let us know if you would also be interested in the following: CC currently accepts HPHC and BCBS for speech.

Speech Therapy

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): | |

General background history

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

| | |
|---|--|
| Parent'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? |
|---|------------|---------------|-----------------------|
| | | | |
| | | | |
| | | | |

Other pertinent background history

- Race (optional): African American Asian Hispanic White/Caucasian Other:
- Parents are currently: Married Separated Divorced Other
- Languages spoken other than English:

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

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: _____

Developmental History:

- Relevant Information Regarding Pregnancy/Birth: _____

- Estimate when your child first:
Rollover _____ Sat up on own _____ Walked _____
Crawled _____ Stood _____ Said phrases _____
Ran _____ Said first word _____

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

| Medicine | Indication | Dosage | Duration of Treatment | Side Effects |
|----------|------------|--------|-----------------------|--------------|
| | | | | |
| | | | | |

Previous Therapeutic Treatments for Diagnosis (i.e. speech/OT) including dates: _____

School/Educational Information (please attach IEP)

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? _____

Phone: _____ Contact Person: _____

May we contact your child's other treatment provider in order to coordinate care? Yes No

Social Life:

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? _____

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
If yes, what issues: _____

CHILD PROFILE

Describe your child's social language skills:

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

Behavior: Please describe any problem behaviors that occur on a consistent basis: (please note: a child's application will not be rejected based on behavioral symptoms).

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

Goals

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

1. _____
2. _____
3. _____

What are your child's favorite areas of interest? Include favorite toys, activities, movies/tv shows, books, foods

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 responsible 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. This release expires when my child is no longer receiving services from Confidence Connection.

Parent / Guardian’s Signature _____
Date: _____

TRANSPORTATION

My child is being transported to camp via:

Name:
Phone Number:
Address:
Relationship to the Child:

Name:
Phone Number:
Address:
Relationship to the Child:

*****If the school is transporting your child please fill out the 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 Confidence Connection's office staff on the day of the transportation change.

Financing:

Confidence Connection Social Summer Program is typically billed as group ABA (social group) to the child's primary insurance. Upon receipt of the application, we will call your child's primary insurance and check/confirm your child's ABA benefits. CC staff will contact you with that benefit information and discuss private pay options if your insurance does not cover the services in full. CC currently accepts HPHC/UBH, BCBS, Aetna, UHC, Tufts Commercial and Tufts Public for ABA therapy.

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.

Application Checklist:

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 completed the insurance registration form and provided a copy of your insurance card.
- You have signed the ABA Consent Form

Next Steps:

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 six months, your child will not need to be screened. If we do not know your child, we will 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 mcottrell@confidenceconnection.org.

We look forward to a great summer!

The staff of Confidence Connection!