second nature
compassion • connection • collaboration

Participant Application

Email: info@secondnaturesocialskills.com
Phone: 508.747.2663
29 South Park Avenue, Plymouth, MA, 02060

Date: _____/_____/_____

☐ **Returning Applicant**	☐ **New** applicant (A one-time $60 enrollment fee applies) This fee includes record review, interview, and formal evaluation to best serve your child's placement needs. *__Due at time of application__*

Name _____

Age _____ **Date of Birth** _____ **Gender: Male Female Non-Binary**

Primary Language: _____

Parent's Name:_____

Address: _____

Phone _____ **Email:** _____

Emergency Contact Person: _____

Emergency Contact: (Home): _____

Emergency Contact: (Cell): _____

Which number do you prefer us to try first while your child is with us? ***Circle One: Home/Cell***

Please list any allergies or accommodations needed in order to participate.

To participate in Individual and Group Services, please submit the following:

_____Completed Enrollment Packet___Copies of all recent evaluations_____Enrollment Fee

_____ ____/____/_____

Parent/Guardian Signature Date

Case History

Clients 18 and over please place NA on lines that don't apply

Participant Name:	
Form Completed by:	**Relationship to Participant:**
Date Completed:	

Background Information

Parent 1: **Age:** **Occupation:** **Highest Grade Completed:**	**Parent 2:** **Age:** **Occupation:** **Highest Grade Completed:**
Parents: married living together separated divorced deceased: parent 1 or 2	
Participant lives with: **Both parents One Parent Other(specify) _____**	
Siblings and age: **1.** **2.** **3.**	
Current School:	
Current Grade:	
Level of Inclusion:	
Counseling/Therapy: type, frequency	
Diagnoses:	
Present Medications:	
Current Behavioral Concerns:	
Discipline Information at home: **Who predominantly provides the discipline:** **Both Parents One Parent Other(specify)_____**	

_____ ____/____/_____

Parent/Guardian Signature Date

EMERGENCY CONTACT INFORMATION

Should the participant incur a serious illness or injury during their session do you give permission to transport the participant to the nearest medical facility? __Yes __No

DETAILS

Name: _____Date of Birth ___/___/_____

Primary Language: _____ Male Female Non Binary

Allergies: _____

Current Medications: _____

EMERGENCY CONTACTS

Please list the details of two people to be contacted in the event of an emergency.

Name: _____

Relationship to participant:_____

Primary Number: _____Secondary Number: _____

Name: _____

Relationship to participant:_____

Primary Number: _____Secondary Number: _____

MEDICAL CONTACTS

Please provide details of the physician or health care provider that you would like us to contact in the event of an emergency:

Name: _____

Address: _____

Phone Number: _____

_____ ____/____/_____

Parent/Guardian Signature Date

Family History

Please specify the family members that have been diagnosed with the following (e.g. Father, Mother, Maternal Aunt, Paternal Uncle, Cousin, etc.):

Attention Disorders: _____

Behavior Challenges:_____

Emotional Challenges:_____

Learning Challenges: _____

Hearing Problems: _____

Autism Spectrum Disorder or related Neurodevelopmental Disability:

_____

Speech and Language Challenges: _____

Intellectual Impairments: _____

Neurological Disorders: _____

Seizure Disorders: _____

Tic Disorders: _____

Anxiety or Depressive Disorders: _____

Other:

_____

We hold this and all information in the strictest confidence. Providing this information gives us a better understanding of your child and their individual needs.

Social-Emotional Development - ***To be completed if child is under 18 years old***

- **Does your child get along with other children? Explain:**
- **Does your child get along with his/her siblings? Explain:**
- **Do your child's special interests interfere with socialization? Explain:**
- **Has your child experienced bullying? Explain:**
- **Does your child like going to school? Explain:**

_____ ____/____/_____

Parent/Guardian Signature Date

- **Has your child experienced trauma in their lifetime? (i.e. difficult divorce, untimely or sudden death of someone close to them, abuse/neglect, exposure to substance use etc.) Explain:**

- **Has your child experienced any of the following: housing or food insecurity, multiple caregivers or foster placements, DCF involvement? Explain:**

- **Does your child prefer to play or work alone? Explain:**

- **Does your child have an understanding of authority figures? (e.g. adults, teachers, police/fire emergency responders) Explain:**

- **Does your child understand and apply time management? Explain:**

- **Is your child easily frustrated? Explain:**

- **When frustrated or angry, does your child hit, kick, punch, bite, break/throw objects etc? Explain:**

- **Does your child work well within a group setting? Explain:**

- **Is your child involved with extracurricular activities? Explain:**

_____ ____/____/_____

Parent/Guardian Signature Date

Therapeutic Services:

Name of Provider: _____Service Provided:_____

Contact Information:
_____

Signature of Consent to Contact:_____

Name of Provider: _____Service Provided:_____

Contact Information:
_____

Signature of Consent to Contact:_____

Name of Provider: _____Service Provided:_____

Contact Information:
_____

Signature of Consent to Contact:_____

Name of Provider: _____Service Provided:_____

Contact Information:
_____

Signature of Consent to Contact:_____

Important: Include a copy of the attendee's most recent evaluation that include, but are not limited to Neuropsychological/Neurology Evaluations, Speech and Language Evaluations, Occupational Therapy Evaluations. If no therapeutic services are provided, place an "NA" on the lines above.

_____ ____/____/_____

Parent/Guardian Signature Date

Insurance Reimbursement Form

Client Information:

Name: _____

Date of Birth: _____Gender: _____

Diagnosis: _____

Address: _____

Phone: _____

Insurance Information

Primary Insurance Company: _____

Identification Number: _____

Group Number: _____

Secondary Insurance Company: _____

Identification Number: _____

Group Number: _____

Insured's Information

Employer: _____

Insured's Name: _____

Date of Birth: _____ Gender: _____

Email: _____

Please provider a copy of the front and back of insurance card/s

_____ ____/____/_____

Parent/Guardian Signature Date

How did you hear about Second Nature Social Skills (please circle one)?

a. **Referral from another participant's family: _____**
b. **AANE (The Asperger/Autism Network)**
c. **Internet Search**
d. **Referral from another source (please name):_____**
e. **Referral from therapist or other medical provider:_____**
f. **Other: _____**

What are at least three things you would like us to focus on?

1. **_____**
2. **_____**
3. **_____**

Please include a copy of the attendees most recent evaluations with this application. Place an NA on line if your child does not have the evaluation.

Relevant evaluations include, but are not limited to:

_____Neuropsychological/Neurology Evaluations

_____Psychological/Mental Health Assessments and Evaluations

_____Speech and Language Evaluations

_____Occupational Therapy Evaluations

_____Individual Education Plans (IEPs)and/or 504 Plans

_____Functional Behavioral Assessment (FBA)

Family Involvement/ FamilyTraining

In order to increase the generalization of skills, promote consistency with behavior strategies, and skill acquisition, parents are required to participate in ABA training **2** times a month if going through their insurance. These may take place in the home (in person or Zoom) or at the Center. Also, 1:1 with a BCBA and/or in a small group with a BCBA.

Please check off below which parent training you would like to register for:

____Saturday Morning (In Person)

____Tuesday Evening (Virtual)

____Other *a BCBA will contact you to schedule (adult clients)

_____ ____/____/_____

Parent/Guardian Signature Date

Program Descriptions:

Antisocial Social Club
Tuesdays 5:00pm-7:00pm
(Late High School & Young Adult)
This group is for older teens and young adults to come together and connect with peers. During this group time, learners will be exposed to lessons & discussions around self-determination, relationships, health & wellness and other topics brought to the group by participants.
Skills targeted during this group include: collaboration, problem solving, self advocacy, growth mindset, safety skills in the community & online, money management, as well as reinforcement of fundamental social skills.

Creation and Innovations
Saturdays 8:00am-10:00am
(Early Elementary)
This group will focus on cooperative, imaginative play, expected and unexpected behavior, and building friendships. Within the second hour of the group participants will work on hands-on creative projects, board game play, and safety within the community.

Social Squad
Saturdays 10:00am-12:00pm
(Late Elementary & Early Middle School)
The Social Squad will focus on peer relationships, friendships, and building communication skills. It will also concentrate on the client's individual needs, what's important to them, and working on barriers that may get in the way. Participants will also go out into the community and work on awareness in the natural environment.

Teens Take the Town
Thursdays 4:30pm-6:30pm
Saturdays 10:00am-12:00pm
(Late Middle School & Early High School)
This group is for teens who are looking for a peer group and a place to practice learned social skills. During the group time, lessons will be focused on more nuanced social skills and scenarios that teens experience in school and with peers (e.g "hidden rules", gray areas). Targeted skills will include perspective taking, self advocacy, problem solving, and self regulation. Topics will vary as we attempt to meet the needs of this group based on interests and real-life social challenges.

Life Hacks: Because Adulting is HARD
Fridays 9:00am-3:00pm
(post High School)
The program will focus on skills & behaviors related to the following areas:
- social
- vocational / employment
- community access / travel training
- health & wellness
- financial literacy
- leisure skills
- special interests
- other personal goals identified by individual participants

Other Services:

1:1 Individual Services (Days & Duration Vary)
Geared toward clients (ages 5-adult) that need learning experience as well as information-based instruction prior to joining a group. We will conduct visits and instruction at your home or within our center. During initial consultation, the clinical team will determine the setting that is most conducive to maximizing teaching and lessening anxiety.
By reducing anxiety, our clients will be able to shift from emotional thinking to intellectual processing.

1:1 SELFIE Therapy 45-60 minute sessions (Days & Duration Vary)
Social Emotional Learning for Independence & Empowerment. All behavior is communication and is an expression of an underlying need. Our Licensed Clinical Social Worker works collaboratively with children and families to problem solve, build strengths, increase confidence, and learn to view challenges from new perspectives. Therapeutic approaches and frameworks include Trauma-informed care, Cognitive behavioral therapy, Dialectical Behavior therapy, Mindfulness-Based Stress Reduction, Family Systems Theory, and Strengths-Based Interventions.

End of session Clinical Team Consult: 1 hour
Scheduled family meeting with a member of our Clinical team to review data and progress at the end of a 6-week session. A Clinical team member will work with families at providing recommendations of programming outside of the center, individual goals for the client, and recommended next steps. Second Nature Clinical staff members will also be available to answer any questions.

_____ ____/____/_____

Parent/Guardian Signature Date

Group Programs:

Placement in groups is based on intake evaluation, developmental level, and fit with the current cohort of participants.

Program:	Fall I Sept 9 - Oct 21	Fall II Oct 24 - Dec 16	Winter I Jan 6 - Feb 17	Winter II Mar 2 - April 13	Spring I Apr 23 - June 8	Day *please circle preferred day and time	Cost: *(All sessions are 6 weeks long except where noted below)*
Creations & Innovations Early Elementary						Saturday 8:00-10:00 am	**$780 per 6-week session**
Social Squad Late Elementary & Early Middle School						Sat 10:00am-12:00pm	**$780 per 6-week session**
Teens Take the Town! Late Middle School & Early High School						Thurs 4:30pm-6:30pm Sat 10:00am-12:00pm	**$780 per 6 week session**
Antisocial Social Club Late High School & Young Adult						Tue 5:00-7:00pm	**$780 per 6-week session**
Life Hacks: Because Adulting is HARD Young Adult and up (Post High School)						Fri 9:00am-3:00pm	**$295 per day**
***SN Clinical Team only** Additional services							***Decided upon intake**

Individual Services:

	Days and times will vary		
1:1 In Home ABA w/ Registered Behavior Tech			**$85 per 60 min session**
1:1 In Home ABA w/Board Certified Behavior Analyst			**$160 per 60 min session**
1:1 SELFIE Mental Health Counseling with Clinical Social Worker			**$160 per 60 min session**
1:1 SELFIE Mental Health Counseling with Clinical Social Worker			**$120 per 45 min session**
End of Session Clinical Team Consult			**$260 per consult (60 min session with written report of progress and recommendations)**
***SN Clinical Team only** Additional services			***Decided upon intake**

_____ ____/____/_____

Parent/Guardian Signature Date

Group Placement and Payment Information:

Group Placement:

Participants are placed in groups by the BCBA and other Second Nature Clinical Staff based on intake process and participants' goals. Second Nature reserves the right to combine or change group times at any time prior to the beginning of a session. We will try our best to accommodate your program selection. *Confirmation email will be sent to the provided email once application, intake, and fees have been completed.

Insurance Coverage:

If your child has a diagnosis of Autism Spectrum Disorder, the cost of programming may be covered by insurance. If you are seeking insurance reimbursement, please complete the Insurance Reimbursement Form and submit along with a copy of the front and back of your insurance card and a Doctor's note (dated within 6 months of registration with Second Nature) stating your child's diagnosis and the need for Social Skills Instruction using an ABA model.

**** Please note that you are responsible for all costs not covered by insurance including co-pays or co-insurance, as applicable. Co-Pays and/or Co-Insurance are due at time of service. Also, for additional programming that is not covered by insurance, a bill for the full amount will forwarded directly to you.****

If your child will be absent (whether group or 1:1 services), 24 hours notice is required. **Families are responsible for the daily program based fee if 24 hours notice is not provided.** Absences can be reported via telephone or through email.

Private Pay/Non-insurance Clients:

Please note that full payment is required regardless of whether your child attends or not. Payments, with the exception of the 1:1 SELFIE Mental Health Counseling sessions, are for 6-week sessions at a time. 50% of the session fee is due by the first day of the session. The remaining 50% is due the 4th week of the session. Non-payment of the program results in suspension of the program until payment is made and may result in loss of your child's slot in that particular session.

Method of Payment:

All invoices are emailed to the primary email provided. Payments may be made directly online using a credit/debit card or dropped off/mailed to Second Nature. Checks should be made out to Second Nature Social Skills. Once payment is rendered receipts will be emailed. **Please note - if you do not receive an invoice or receipt in your inbox, please check your spam folder.

Scholarship:
Scholarships are available for qualified families.Please email info@secondnaturesocialskills.com to request an application.

_____ ____/____/_____

Parent/Guardian Signature Date

Applied Behavior Analysis (ABA)
Group Parent Training Confidentiality Form

I, _____, understand and will comply with the confidentiality clause at Second Nature Social Skills' support/training groups. In these group trainings, you may hear events or situations from other families and /or share your own situations and events with other families.

Being confidential means, what is said and shared in group trainings remains private and does not leave the group. It means not sharing information or retelling information that you have heard within the group setting to others. What happens in group trainings stays in the group trainings. Any written information seen may not be shared or repeated as well.

This group training is a supportive environment and when we are sharing our stories with another, we are empowering ourselves and building solidarity with one another. By signing this form, I am acknowledging and accepting the confidentiality clause for being of the Applied Behavior Analysis (ABA) Group Parent Training.

_____ ____/____/_____

Parent/Guardian Signature Date

Parent/Legal Guardian Waiver, Release and Responsibility Form

Please read carefully and initial next to each section and sign and date the bottom of the page. By signing below, I indicate that I understand and agree to the items initialed above.(page 1 of 2)

_____A. General Liability Waiver

I, _____, being the parent/guardian of _____, do hereby consent to his/her participation in voluntary projects and functions sponsored and /or organized by Second Nature Social Skills, its members, and its staff (hereafter referred to as Second Nature. I understand that he/she is responsible for his/her behavior. I do hereby waive and release Second Nature, their service partner (including schools) and or sponsors of any project, event, or function, from all claims and liabilities, of any kind whatsoever, arising from, whether directly or indirectly, my child/ward's participation in Second Nature organized and/or sponsored projects or functions.

_____B. Transportation Liability Waiver

I do hereby consent to Second Nature providing transportation (in private vehicles) for my child/ward if necessary. I understand this service is not guaranteed. I do hereby waive and release Second Nature their service partners and/or sponsors of any project or function, from all claims and liabilities, of any kind whatsoever, arising from, whether directly or indirectly, my child/ward's involvement in transportation services provided by Second Nature.

_____C. Release to Seek Medical Treatment *

In the event of a medical emergency, I do hereby consent to Second Nature releasing my child/ward to the nearest, most appropriate medical professional available. I understand that Second Nature will notify me of such an event immediately after they have sought proper medical treatment for my child/ward. Second Nature should contact me at the following phone number: _____.

If your child/ward has a chronic or recurring condition, for which emergency treatment is not necessary, please discuss your child's /ward's needs with Second Nature directly.

_____D. Photo/Video Release

I hereby grant Second Nature permission to use my child's/ward's likeliness in a photograph/video in any of its publications, including website entries, without payment or any other compensation. I understand and agree that these materials will become property of Second Nature and will not be returned.

_____E. Video Release

I hereby grant Second Nature permission to use my child's/ward's likeness in a video for educational purposes. I understand that it will be shared and reviewed with other video participants, the video participant's parents/guardians, Second Nature Educators, and attendees at Second Nature sponsored educational events.

_____F. Group Commitment and Responsibility

Our staffing and financial commitments are based on client's registrations; therefore, I understand that I am responsible for full payment of the entire group session (winter, spring, summer, or fall) regardless of missed sessions. For planning purposes and for the other group participants, I agree to give at least 24 hours advance notice, via telephone/email, if my child/ward is going to miss a session.

_____G. Insurance Based Clients

I understand that I am responsible for the daily program-based fee if I fail to provide Second Nature with 24 hours advance notice via telephone/email of my child/ward's absence.

_____ _____/_____/_____

Parent/Guardian Signature Date

Parent/Legal Guardian Waiver, Release and Responsibility Form

Please read carefully and initial next to each section and sign and date the bottom of the page. By signing below, I indicate that I understand and agree to the items initialed above.(page 2 of 2)

____H. Payment Policy
I understand that I am responsible for payments at the time I have indicated on page 8 and failure to do so will result in suspension of services until payment is made.

___I. Physical Exam and Immunization (Public School and/or Public Health Requirements)
I certify that documentation of a physical exam and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements, are on file at my child's/ward's/self's school.

___J. COVID-19 Screening
I certify that I will perform a COVID-19 Screening and will be done each day prior to my child/ward/self attending the program, including but not limited to a temperature check.

___K. Family Training
In order to increase the generalization of skills, promote consistency with behavior strategies, and skill acquisition, I understand that I am required, through my Insurance company, to participate in parent group or individual consultation **2** times a month. These may take place in the home (in person or Zoom) or at the Center. Also, 1:1 with a BCBA and/or in a small group with a BCBA. I understand failure to do so could result in suspension of services and or termination of insurance coverage.

____L. Family Communication and Involvement (18 and over clients)
Since I am over the age of consent (18 years old), I give permission for Second Nature Social Skills staff to communicate with my parents/caregivers, _____. This is in full force and in effect until I contact Second Nature Social Skills in writing to inform them otherwise. This contact will enhance my scheduling, billing, and group management/communication. It will not include session sensitive information without a signed Release of Information Form.

_____ ____/____/_____

Parent/Guardian Signature Date

Email: info@secondnaturesocialskills.com
Phone: 508.747.2663
Address: 29 South Park Avenue, Plymouth, MA, 02060

Child's Name: _____

Release of Information Waiver Form

I, _____, hereby, give permission to the authorized Second Nature Social Skills, LLC staff, permission to on behalf of my child_____, in the following capacities:

_____ verbally, on the phone or in person

_____ in writing, either electronically or via mail form

_____ release of records

Circle communication level: TO FROM BOTH

Name of School/Agency:_____

Name of Personnel:_____

Address:_____

Email:_____Phone:_____

By signing this waiver, I hold Second Nature Social Skills, Inc., harnessed from privacy rules and laws, as this signature provides my consent to the release of this information. This shall remain in full force and effect until I write a letter requesting to stop the release of information to this community resource.

By signing this form, I understand that this allows Second Nature Social Skills staff the ability to discuss any pertinent information regarding my child with school/clinical personnel.

Child's Name _____Date of Birth_____

_____ _____ ___/___/___

Parent/Guardian Name Parent/Guardian Signature Date

_____ ____/____/_____

Parent/Guardian Signature Date