Elevated Abilities
Growing Better Together

Social Skills Intake Form

CLIENT INFORMATION

Client Last Name: _____ Client First Name: _____

Preferred/Other Name: _____ Client Birthdate: _____ Sex: ____

Current FSCD Contract: ◯ YES ◯ NO FSCD Number (if applicable): _____

FSCD Worker (if applicable): _____

Client Diagnosis: _____

FAMILY INFORMATION

Parent/Guardian #1 Last Name: _____

Parent/Guardian #1 First Name: _____

Email Address: _____ Phone Number: _____

Primary Language Spoken: _____

Address: _____

Parent/Guardian #2 Last Name: _____

Parent/Guardian #2 First Name: _____

Email Address: _____ Phone Number: _____

Primary Language Spoken: _____

Address: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____

Relationship to Client: _____

Email: _____ Phone Number: _____

Address: _____

Parent Initial: _____

DESCRIPTION OF PROGRAM

In this 12-week program, your child will learn skills to cope with challenging situations within play environments. They will learn to take turns, follow their peer's lead in play, cope with losing, and problem-solve. Children will be participating in video recordings for programming purposes.

CLIENT PREFERENCES

What are some of your child's strengths:

What are some of your child's preferred/favourite activities:

What are some of your child's hobbies/interests:

CLIENT PROFILE

Please provide the following information as accurately and best as possible. This will ensure that your child has a successful experience in the program.

COMMUNICATION

Please describe the current level:

Parent Initial: _____

BEHAVIOUR

- ☐ Runs away
- ☐ Non-Compliant/Doesn't Follow Directions
- ☐ Impulsive
- ☐ Self-Injurious
- ☐ Aggressive Behaviours
- ☐ Challenges with Transitions

If any boxes are checked, please describe:

PLAY AND SOCIAL SKILLS

Please describe the current level:

OTHER INFORMATION

Parent Initial: _____

AGREEMENT FOR ATTENDANCE AND PAYMENT

PAYMENT INFORMATION

The fee for the Social Skills program is $1200.00 for the 12-week program. Direct billing is available for clients with current and active FSCD contracts. Parents must pay $200.00 at the program's start, and the remaining amount will be directly billed monthly with an approved invoice. If applicable, a copy of an active FSCD contract will need to be provided before starting the program. If there is no FSCD contract, then the family will be responsible for paying the entire amount.

☐ Active FSCD Contract

☐ Private Pay (Cash / Cheque / Credit Card / E-Transfer)

CANCELLATIONS and/or POOR ATTENDANCE

Due to the schedule of sessions, we cannot make up in-person sessions lost due to missed sessions. The family will be provided with the materials created that were covered during the missed session. With the nature of the week-to-week sessions, it is important that attendance is 100%; if more than 3 sessions are missed, removal from the program will be discussed.

Cancellations must be made 24 hours before the scheduled session to ensure materials can be provided on time. If cancellation occurs, the family will be invoiced for 50% of the session.

INVOICING POLICY

Caregivers must sign monthly invoices provided via email; unless other arrangements are made, you have one week (7 calendar days) from receiving the invoice to approve it. If you do not sign and return this invoice in one week, your programming will be placed on hold until the invoice is approved. Approval can be done by replying to the email typing “APPROVED”, signing the invoice, and scanning it back. Questions regarding your invoice can be directed to your Coordinator or the billing department.

Parent Initial: _____

ILLNESS POLICY

It is important to us that all our clients and staff stay as healthy as possible, especially during cold and flu season. We ask that families let us know right away if their child is ill.

Your child will be deemed unable to attend programming if they have any of the following symptoms or illnesses within 24 hours or upon arrival:

- Uncontrolled diarrhea (stool runs out of the diaper, child can't get to the toilet in time, or 3 or more bouts of diarrhea in one day)
- The child does not feel well enough to participate comfortably in the usual therapy activities
- A temperature of 100°F or greater
- Vomiting (vomiting must be stopped for 24 hours or a health professional must have given written permission indicating that it is safe for the child to resume therapy)
- Discharge from the nose that is persistent and yellow or green in colour (not associated with allergies)
- Pink eye with white or yellow discharge (therapy must not be resumed until 24 hours after treatment has started)
- Rash with fever or behaviour change
- Mouth sores with drooling unless a health professional determines the child's illness is not contagious
- Scabies, head lice, or other infestation (therapy may resume 24 hours after treatment starts and the child is nit-free)

APPLICATION PROCESS

Parents/Caregivers must complete a full intake application to ensure this program is suitable for the child. A phone call will take place to understand the child better. If the client needs to gain pre-requisite skills, they may be referred to an alternative program to develop missing skills.

PARENTAL/CAREGIVER INVOLVEMENT

Parental/Caregiver involvement will be integral to the child's progress. There will be weekly homework for the child and family to complete and check-ins with the parent/caregivers. Without this involvement, the treatment outcome can be negatively impacted.

Parent Initial: _____

HOUSEKEEPING ITEMS

- Snacks/Food – Clients are welcome to bring snacks and water in the program. We will not have access to a fridge or microwave
- Communication Process – Please email or use Class Dojo to connect with the therapist
- Doors open at 4:25PM and sessions start at 4:30PM
- Parking and Location will be provided

RECORDING POLICY

Children and staff will be recorded in this program for internal purposes. These videos will be integral to the success of this program. Video recordings will not be used for any other purpose unless consent is given. Check the consent level you are comfortable with.

☐ I give Elevated Abilities consent to use videos in the current **and** future programs.

☐ I give Elevated Abilities consent to use videos in the current program.

☐ I give Elevated Abilities consent to use videos in Social Media/Marketing materials (parents/caregivers will be present with material for approval for publishing)

The Social Skills group will use a program called Class Dojo to act as an intermediate between the families and the therapist. This program is secure and offers communication, sharing, and storing of files. More information will be provided.

Parent Initial: _____

CONSENT

I, _____, hereby give consent for:

- ☐ Provide and Release information to professionals within Elevated Abilities for the purpose of clinical support as deemed necessary
- ☐ Provide and Release information to professionals within FSCD for the purpose of clinical support as deemed necessary
- ☐ Provide and Release information to professionals within other professionals for the purpose of clinical support as deemed necessary
  Please specify: _____

I understand that the above policies and procedures and have provided accurate and up-to-date information about the client.

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____

Please send completed forms to info@elevatedabilities.ca

Parent Initial: _____