Once complete, please email your application to

TLCABA@andrewscenter.com

Or drop it off at our front desk. We are located at 1722 West Front Street, next to the Rose Garden!

Consumer's Name: _____

2021 Application for Peers® Social Group

Andrews Center: Treatment and Learning Center
1710 West Front St.
Tyler, Texas 75702
Phone: 903 593-4004 Fax: 903-593-4121 Email: TLCABA@andrewscenter.com

Thank you for your interest in TLC's Peers ® Social Group. At the Treatment and Learning Center (TLC), we are dedicated to piecing together our East Texas Community by providing quality Applied Behavior Analysis (ABA) tailored to meet the needs of each child and teach them how to better communicate and interact with their environment, family, friends, and teachers.

Upon submitting your application, you will be contacted by a staff member who will do a screening to ensure that the Social Group is the proper fit for your child. If your teen struggles behaviorally or is not quite ready for group social training, then we may recommend applying for one of our other ABA programs!

TLC's Peers® Social Group

PEERS (Program for the Evaluation and Enrichment of Relational Skills) is a parent-assisted intervention focusing on teens in middle school and high school who are having difficulty making or keeping friends. It is the developmental extension of an evidence-based program known as Children's Friendship Training (Frankel & Myatt, 2003). PEERS has been field tested most extensively on teens with autism spectrum disorders (ASDs), to a limited extent on teens with developmental disabilities and fetal alcohol spectrum dis-orders (FASDs), and is currently undergoing testing with teens with attention-deficit-hyperactivity disorder (ADHD).

The intervention includes separate parent and teen sessions that meet at the same time for 90 minutes each week over a 14-week period. The group focuses on skills like having conversations; entering and exiting conversations; using electronic forms of communication; choosing appropriate friends; handling teasing, bullying, and other forms of social rejection; handling arguments and disagreements with friends; and having appropriate get-togethers with friends, including how to be a good host and a good sport.

Funding (We will evaluate and finalize funding sources with you)**:**

- ○ Focus Grant
  - Age must be between 12-15 years with an Autism Spectrum Disorder diagnosis
- ○ Private Insurance
  - Private insurance will be verified to determine coverage
- ○ Out of Pocket
  - $35 per hour ($52.50 per session)

How did you hear about us?

- ○ Referred by: _____
- ○ Other:_____

Consumer's Name: _____

ALL INFORMATION IN APPLICATION IS REQUIRED FOR SERVICES

Today's Date _____/_____/_____

IDENTIFYING INFORMATION:

Child's Full Name:	Date of Birth:		Age in Years:	
Social Security Number:	Child's Gender:		Language Spoken in Home:	
Height: *ft.* *in.*	Weight: *lbs.*		Race/Ethnicity:	
Address:	City:	State:	Zip Code:	County:

DIAGNOSIS INFORMATION

Diagnosis/Diagnoses:	Doctor who provided diagnosis:
Age at Diagnosis:	Year diagnosis was given:

FAMILY INFORMATION

Parent/Guardian Name:	Relationship to child:
Address (if different from child):	City, State, Zip:
Phone Numbers Cell/Home: Other:	Email Address:
Additional Parent/Guardian Information	
Parent/Guardian Name:	Relationship to Child:
Address (if different from child):	City, State, Zip:
Phone Numbers Cell/Home: Other:	Email Address:
Family Size:	Gross Annual Income for Family:

Consumer's Name: _____

FUNDING INFORMATION

Does your child have CHIP? **Yes** **No**	CHIP Number:
Does your child have Medicaid? **Yes** **No**	Medicaid Number:
Does your child have Medicare? **Yes** **No**	Medicare Number:

Does your child have private insurance? **Yes** **No**	Insurance Company:
Insurance Phone Number:	Insurance Address:
Policy Holder Name and DOB:	Relationship to Consumer:
Policy Number:	Group Number:

Please attach required documentation:

- ○ Autism Diagnosis Report (must be medical doctor or PsyD)
- ○ Copy of insurance card
- ○ Proof of Texas Residency (i.e., Texas Driver's License, electric bill, etc.)
- ○ Proof of Income (tax return or 3 pay stubs)
- ○ HHSC Form 6000
- ○ HHSC Cost Share Attestation
- ○ Custody Agreements (if applicable)
- ○ Individualized Education Plan (if applicable)

Consumer's Name: _____

Please initial:

_____ I would like to be contacted by a current or former TLC parent regarding their experiences and what to expect.

_____ I would like to be added to the TLC email list for information regarding events, trainings, etc.

Feel free to visit our Facebook page at https://www.facebook.com/treatmentandlearningcenter/ or our website at tlcaba.org

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date:_____

Form 6000
April 2017

TEXAS Health and Human Services

Children's Autism Program Enrollment

If multiple children in the household are being enrolled in the Children's Autism Program, use a separate enrollment form for each child.

Family Information

Child's first name:	Middle name:	Last name:	Birth date:

Parent's or guardian's name: Relationship to child:	Telephone: ( ) Email:	Child's sex: ☐ Female ☐ Male

Address:	City:	State: TX	ZIP code:

Diagnosis:	Age at diagnosis:	Language spoken:	Race and/or ethnicity:

Proof of Texas residency:	County:	Family size:

Income Information

Select all that apply:

☐ Gross income	Amount: $
☐ Allowable deductions	Amount: $
☐ Adjusted gross income	Amount: $

Insurance Information

Do you have CHIP?	☐ Yes	☐ No	CHIP Number:
Do you have Medicaid?	☐ Yes	☐ No	Medicaid Number:
Do you have Medicare?	☐ Yes	☐ No	Medicare Number:

Do you have insurance? ☐ Yes (If yes, complete insurance information below.) ☐ No

Insurance carrier's name:	Policy holder's name:
Referral source:	Previous ECI services: ☐ Yes ☐ No

Signature

I certify that the statements made for the Children's Autism Program Enrollment application are true and correct to the best of my knowledge.

Parent's, guardian's, or caretaker's signature: **X**	Date of signature:

For Office Use Only

Case ID number:	Enrollment date:

Children's Autism Program
Family Cost Share Attestation Worksheet

Instructions to Contractors: If the family has an income tax return, use the adjusted gross income to determine the cost share. If the family does not have an income tax return, complete this form with the family to determine the annual income and deductions for the family. The parent or guardian of the child must sign the form attesting to the contractor that the information they provided on this form is correct.

Gross Income for the Year

Total all the income received by the individuals included in the family size, from whatever source, that is considered income by the Internal Revenue Service before federal allowable deductions are applied. A copy of the family's paycheck stubs or other forms of documentation need to be submitted with this form to confirm gross income reported.

Income Type	Parent 1	Parent 2	Child and Other Dependent(s)	Total
Wages, salaries, tips				$
Self-employment income				$
Unearned income such as retirement benefits or child support				$
Unemployment benefits				$
Dividends and interest				$
Other: SSI or other disability income such as Social Security due to disability or Veteran's disability is not countable income but make note that the family receives it.				$ 0 (not countable)
			Grand Total	**$**

Allowable Deductions

Allowable deductions include expenses not covered by insurance. The deductions may be medical or dental expenses to alleviate or prevent a physical or mental defect or illness and limited to the cost of:

- diagnosis, cure, alleviation, treatment, or prevention of disease;
- treatment of any affected body part or function;
- legal medical services delivered by physicians, surgeons, dentists, and other medical practitioners;
- medication, medical supplies, and diagnostic devices; and
- transportation to receive medical or dental care.

Allowable Deduction Type	Parent 1	Parent 2	Child and Other Dependent(s)	Total
Medical or dental expenses not covered by insurance (as determined by the above criteria)				$
Co-pays, co-insurance, and deductibles				$
Medical or dental debt that is being paid on an established payment plan				$
Childcare and respite expenses				$
Costs and fees associated with the adoption of a child				$
Court-ordered child support payments for children who were not counted as family members or dependents in calculating the adjusted income and family cost share amount				$
			Grand Total	**$**

Adjusted Income (used to determine Family Cost Share)

Gross Income	$	- Allowable Deductions	$ -	= Adjusted Income	$

I attest the information included on this form is correct.

Parent (or guardian) signature: _____ Date: _____