Anderson Center Consulting & Training

MEETING THE NEEDS OF OUR COMMUNITY

Anderson Center Consulting & Training
Social Skills Program
Application Checklist

The completed Application Packet should consist of:

- ☐ Completed Social Skills Program Application
- ☐ Completed Consent Form (required)
- ☐ *Completed Consent to Use Email or Other Electronic Media to Exchange Personally Identifiable Information form (optional)*

Please return all completed forms by mail, fax or eMail to:

Mail:

Lisa Susczynski
Consultation Administrator
Anderson Center Consulting & Training
4885 Route 9 P.O. Box 367
Staatsburg, NY 12580-0367

Fax: 845-889-9496

eMail: ACCT@AndersonCares.org

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MEETING THE NEEDS OF OUR COMMUNITY

Anderson Center Consulting & Training
Social Skills Program Application

We ask that the applicant complete the application as independently as possible.

Referral Source: _____

Applicant Information

Name: _____Date of Birth: _____Gender: _____

Street Address:_____

_____

Billing Address if different: _____

_____

Guardianship/Custodian

Complete this section if the applicant has a legal guardian

☐ Legal Guardian Name: _____

Family Information

Parent/Legal Guardian:_____Relationship to Patient: _____

Street Address:_____

_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Email address: _____ Occupation_____

Parent/Legal Guardian:_____Relationship to Patient: _____

Street Address:_____

_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Email address: _____ Occupation_____

Emergency Contact

Emergency contact: _____ Relationship to Patient: _____

Street Address:_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Payor Information

Complete this section if someone other than the applicant or parent(s)/guardian(s) will be responsible for payment of program fees, if the applicant is accepted and participates in the program.

Payor's Name:_____Relationship to Patient: _____

Street Address:_____

_____

Billing Address if different: _____

_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Email address: _____

Medical Information (optional) (Intended for use in emergent situations only as necessary)

Please list all medications currently being taken by the program applicant.

Medication:	**Prescribed For:**

Does applicant self-administer medications, including an Epi Pen, if necessary? ☐ Yes ☐ No ☐ N/A

Please check any conditions below that the program applicant has/has had:

Condition		**Condition**	
Diabetes		Hearing Loss/Difficulty Hearing	
Asthma/Respiratory Difficulties		Vision Difficulties	
Seizure disorder/Epilepsy		Physical Challenges	
Cardiac Issues/Heart Disease		Season Allergies	
Feeding/Swallowing Disorders		Food Allergies (please list)	
Sleep Disorder		Any other disease; please list	
Anxiety/Depression			

Please list any known food allergies:

_____

Are there any other medical or mental health conditions/surgeries/hospitalizations that may impact participation in the Social Skills Program (e.g., back surgery may limit ability in hiking or related activities, suicidal thoughts may pose safety concerns)? If so, please describe:

_____

_____

Behavioral Concerns

If challenging behavior(s) are experienced, are you able to utilize coping skills?
☐ Yes ☐ No ☐ N/A

_____

_____

Current Services: School, College, Day Placement

Name of School/College/Program: _____

Date of Enrollment: _____ Grade: _____

Major/Program (if college): _____

Applicant Skills and Preferences

We ask that this section be completed by the applicant:

Participation in Other Programs

Have you previously received social skills instruction? ☐ Yes ☐ No ☐ Unsure
If yes, please list name of teacher or agency providing instruction and year(s) of participation.

Have you previously participated in Social Skills clubs, camps, or programs? ☐ Yes ☐ No ☐ Unsure
If yes, please provide the name of the club(s)/camp(s)/program(s) and the year(s) of participation.

Social Skills

Do you encounter difficulty or deficits in any of the following areas?

Social Skill	Area of Strength	Area of Difficulty	Comments
Group Activities			
Transitioning from one activity to another			
Going to a store			
Making friends			
Social boundaries			
Riding in the car			
Getting on/off school bus			
Eating out			
Securing/keeping a job			
Attending community activities			

What activities or interests do you prefer (i.e., singing, movies, multi-player gaming, etc.)?

Goals/Outcomes

Why are you interested in participating in the Social Skills Group program? (e.g., to make friends, learn and practice skills to meet people, use at work or in the community, etc.)

List 3 things you hope to learn through the Social Skills Group instructional sessions:

_____

_____

_____

By signing below, I verify that the information above is accurate and inclusive to the best of my knowledge.

_____ _____

Applicant's Name Date

_____ _____

Applicant/Legal Guardian Signature Printed Name of Legal Guardian (if applicable)

Please return this form and all documentation to:

Lisa Susczynski
Consultation Administrator
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