

REGISTRATION FORM 2022-2023

Please be sure to fill out the front and back of this form.

Please return completed form to Reading office.

New Application Re-enrollment

I am interested in enrolling my child _____ in The Triumph Center's social skills group program.

SEPTEMBER THROUGH JUNE SCHEDULE

PLEASE INDICATE ALL POSSIBLE DAYS AND TIMES YOUR CHILD COULD ATTEND

Monday	3:30-4:20	4:30-5:20	Thursday	3:30-4:20	4:30-5:20
Tuesday	3:30-4:20	4:30-5:20	Friday	3:30-4:20	
Wednesday	3:30-4:20	4:30-5:20			

Sites I am interested in (circle all possible): READING LEXINGTON*

*Additional Days May be Offered

(Tues, & Wed)

Please note: It is possible that we may not have an appropriate group at your preferred site, day, or time. If you are able to travel to other sites it will increase the likelihood that we will have an appropriate group for your child. Likewise, increased flexibility regarding the day and time of the group increases the chances of a good match for your child.

Child's Name: _____ **Date of Birth:** ___/___/___ **Age:** ___ **Grade:** ___

Parent Name (1): _____ **Parent Name (2):** _____

Guardian's Name(s): _____ **Email:** _____

Home Phone: _____ - _____ - _____ **W#:** _____ - _____ - _____ **C#** _____ - _____ - _____

Address: _____ **Town/Zip:** _____

Fees: Interview fee (if applicable): \$125.00. Acceptable method of payment cash or check.

Group program: \$950.00 for a fourteen-week session (\$60.00 per session plus \$110.00 programming fee to cover the cost of regular educational feedback sessions) **if paying out-of-pocket and not utilizing health insurance**. All children are required to attend at least **one** 14-week session regardless of their starting date.

PLEASE SEE BACK OF PAGE

Important Insurance Information: The Triumph Center is a provider for **some** BCBS, HPHC & TUFTS insurance plans. Please contact our office to find out whether your insurance will pre-authorize group services and pay for a portion of your behavioral health benefits. With the exception for covered plans, you will be responsible to pay for your child's group in advance and will then be reimbursed directly by your insurance company. When applicable, we will work with you to complete the necessary paperwork in order for you to utilize your insurance benefit for the group program.

IF ATTEMPTING TO PAY BY INSURANCE:

Name of Insurance Company: _____

Address: _____

Name of Person Insured: _____

Phone: _____

Insurance ID#: _____

Employer's name if coverage is provided by employer: _____

Insurance Plan or Program Name: _____

Do you have a deductible? ___ YES ___ NO If yes, how much is it? _____

Do you have a Copay? ___ YES ___ NO If yes, how much is it? _____

If your insurance pays only a percentage, how much do they cover (in percentage)? _____

IF SCHOOL DISTRICT OR OTHER AGENCY HAS AGREED TO PAY:

WE NEED A SIGNED CONTRACT FROM THE SCHOOL DISTRICT OR AGENCY BEFORE THE CHILD CAN BEGIN TO ATTEND GROUP.

Name of School District or Agency: _____

Contact Person: _____ Phone: _____ - _____ - _____

Billing Address if Known: _____

Notes: