



TEEN GROUP-Fall 2021

Description "Teen group" is:

- for teens diagnosed with Asperger's Disorder or High Functioning Autism
- designed to improve friendship behaviors and social skills
- designed to provide support for teens who may be isolated from peers
- designed to promote self-esteem through successful experiences
- designed to help improve the ability to act positively and effectively with others
- designed to have a maximum of 10 per group
- developed and directed by Michelle DePolo, Psy.D., Child/Pediatric Psychologist
 - o Facilitated by Rachel Kallin, BCBA, Ed.D & Lindsey Trump, BCBA, Ed.S

How

The program promotes social development, friendship skills, and self-esteem as well as addressing current issues and problem solving skills in a group format:

- Sessions will be held in person and Teen participants will be guided through discussions on topics including but not limited to:

making/keeping friends	conversational manners	reducing social anxiety
resilience from depression	non-verbal communication	responding to teasing
two-way conversation	sportsmanship/losing	staying on topic
building self-esteem	understanding social cues	problem solving

Who: "Teen group" is for:

- Teens who are in middle school or high school
- Teens diagnosed with Asperger's Disorder or High Functioning Autism
- Teens who have primary placement in a regular education setting
- Teens who have generally average speech and language skills

When and Where

- Thursday evenings from 5:00-6:00p.m.
 - Groups meet for 1 hour for a 9 week program - this sessions will be in person

Fall 2021 DATES:
September 23
September 30
October 7
October 14
October 21
October 28
November 4
November 11
November 18

Cost

- The program fee is \$450
- To reserve your spot, please send payment of \$100 with the attached application. The remaining \$350 is due at the first group
- Per guidelines of your insurance, the program costs may be reimbursable under the CPT code 90853 (group psychological treatment).

Application and Enrollment Process

- Please complete the attached application and return it with your payment to: KidsLink NeuroBehavioral Center 899 Frost Road Streetsboro, Ohio 44241 Attention: Katrina Mullen
- **Parents are asked to register by September 16, as enrollment is limited.** Call KidsLink at 330-963-8600 with any questions.

We look forward to working with you and your teen!



TEEN INFORMATION:

Name: _____ DOB: _____ Age _____

Address: _____

Medical Problems (if any): _____

Medications (if any): _____

FAMILY INFORMATION:

Mother's Name: _____ Home Phone: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____ Work Phone: _____

Parents are: _____ Married _____ Separated _____ Divorced;

If divorced: _____ shared parenting _____ primary custody with _____

Siblings (Names and Ages): _____

EDUCATION INFORMATION

What is the name of your child's school? _____

What grade is he/she in? _____

Please describe your child's current educational program (i.e., regular education, inclusion, special education services, supplemental therapies, etc.):

What are your goals for your child's participation? You may wish your child to develop certain skills, for example. If so, name the skills.

Please describe the best things about your child.
