**2024 Transition Group**

Professionals at the Shirley Ryan AbilityLab are committed to empowering adolescents to become more independent by preparing them for a smooth and successful transition toward the future. The transition program provides skill training for patients. Caregiver education and involvement is also key to the program. The units covered within the program include: community transportation, money management, cooking, medical information and care, and education and employment. The Young Adult Transition program is held in person and will include one individual speech therapy session and one group session per week. See Flyer For Dates/Times.

**Participant Requirements:**

* Age 13-21, split into two groups
* Independent with toileting or caregiver available if needed

**A physician referral/prescription is required to participate in the group. Participants must have an insurance policy that will cover group therapy.**

Please contact your insurance company to inquire if your child’s benefits cover “group therapy” code: 92507 and/or 92508. For more information on insurances we currently accept, please see our website: <https://www.sralab.org/contact/insurance>. Here you will also find the numbers to contact for patient financial services and our managed care teams. **Parents are responsible for knowing insurance limitations with therapy coverage.**

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| I have checked my insurance and it does cover group therapy code 92507 and/or 92508 |  ☐  |  ☐  |
| I **HAVE** used other therapy benefits elsewhere |  ☐  |  ☐  |
| If checked yes to the previous question, please use this line to enter how many visits have been used elsewhere. Family is responsible for knowing their max visits.  | Visit Number: |  |
| I understand that I am liable for any additional charges that my insurance does not cover |  ☐  |  ☐  |
| I **HAVE** a visit limit  |  ☐  |  ☐  |
| If checked yes to the previous question, please use this line to enter how many visits are allowed. Family is responsible for knowing their max visits. | Number of visits: |  |
| Max amount of units allowed per day  | Unit number allowed: |  |

 Patient Full Name Patient DOB

Printed Parent Name Parent/Legal Guardian Signature

**2024 Transition Group**

**Please print and complete all entries**

Patient Name: Patient Birth Date:

Address: Caregiver Name:

Home Phone: Cell Phone:

Caregiver Email:

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Primary Doctor/Pediatrician:

Ordering Physician (for camp):

Emergency Contact: Relationship:

Phone Number:

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**Insurance Information Insured/Responsible Party**:

Relation to Patient:

Birth Date:

Address (if different from patient):

**Primary Insurance:**

Address:

Phone Number:

Group Number: ID Number:

**Secondary Insurance:**

Address:

Phone Number:

Group Number: ID Number:

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