Barber Behavioral Health Institute

Children's Acute
Partial Hospitalization Program Application

Fax to Attn: Kaleena Howell at (814) 833-0382
Please fill out as thoroughly as possible

Name of Applicant:		Date Completing Form:	
County of Residence:	☐ Erie ☐ Other:	Age:	
Race:		Gender:	
Date of Birth:		SSN:	
Parent/Guardian to Contact:		Home Phone:	
Address:		Work Phone:	
City, State, Zip Code:		Cell Phone:	
Height/Weight:		History of Suicidal Ideation: Y N	Explain:
History of Self-Injurious Behaviors: Y N	Explain:	History of Domestic Violence: Y N	Explain:

PARENT INFORMATION: Father			
Name:			Home Phone:
	Last	*First*	Cell Phone:
Check if address is same as Applicant ☐ If different please list below			
Physical Address	*City/State/Zip Code*	*Mailing Address*	*City/State/Zip Code*

PARENT INFORMATION: Mother			
Name:			Home Phone:
	Last	*First*	Cell Phone:
Check if address is same as Applicant ☐ If different please list below			
Physical Address	*City/State/Zip Code*	*Mailing Address*	*City/State/Zip Code*

GUARDIAN INFORMATION: **(Complete ONLY if COURT APPOINTED LEGAL GUARDIAN)**			
Name:			
	Last	*First*	*Relationship*
Check if address is same as Applicant ☐ If different please list below			
Physical Address *City/State/Zip Code*		*Mailing Address* *City/State/Zip Code*	
Phone Numbers	Home Phone		
	Cell Phone		
	Work Phone		

MA/Access Number		Card Issue Number	
Funding	☐ CCBH ☐ HIPP		
Private Insurance Company			
Name of Insured		Relationship to Child	
Individual ID		Group ID	
Insured Birth Day		Insured SSN	

Applicant's Current Diagnosis	
Psychosocial and Contextual Factors	
Does the Applicant have any medical concerns?	☐ No ☐ Yes
If Yes, Note	
Date of Evaluation/Evaluator	
Does the Applicant need to take medications during acute PHP hours?	☐ No ☐ Yes
If Yes, Medication Name and Time	
What other medications does the Applicant take? Name/Dosage/Time	

Current School		Current Grade	
School Contact		School Contact Number	
Classroom Setting		Support Plans	

Does the Applicant currently receive any of the following services?				
	Current	Previous	Dates / Agency	Contact person/ Phone Number
BHRS				
Blended Case Management				
Family Based Mental Health				
Outpatient Therapy				
Psychiatrist/Psychologist				
☐MST ☐ FFT				
Partial Hospitalization (School Based/Acute)				
Inpatient Hospitalization				
JPO				
OCY				
Other - _____				

Please state the reason for referral:

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Strengths:

Applicant: _____
_____
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Family: _____
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_____

Name of person completing this form:	
Relationship to Applicant:	
Phone Number:	
Signature:	