Barber National 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:		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:
Physical Address: Check if Same as Child, otherwise please provide below ☐		Mailing Address: Check if Same as Physical, otherwise please provide below	
Street Number & Name	*City/State/Zip Code*	*Street Number & Name*	*City/State/Zip Code*

PARENT INFORMATION: Mother			
Name:			Home Phone:
	Last	*First*	Cell Phone:
Physical Address: Check if Same as Child, otherwise please provide below ☐		Mailing Address: Check X if Same as Physical, otherwise please provide below	
same	same		
Street Number & Name	*City/State/Zip Code*	*Street Number & Name*	*City/State/Zip Code*

GUARDIAN INFORMATION: **(Check this box ONLY if COURT APPOINTED LEGAL GUARDIAN)**			
Name:			
	Last	*First*	*Relationship*

Physical Address: Check if Same as Child, otherwise please provide below X	
Street Number & Name	City/State/Zip Code

Phone Number: same	( ) -	*(Home)*
	( ) -	*(Cell)*
	( ) -	*(Work)*

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	

Child's Current Diagnosis	
Psychosocial and Contextual Factors	
Does the child have any medical concerns?	☐ No ☐ Yes
If Yes, Note	
Who was the evaluator? And Date:	
Does the child need to take medications during acute PHP hours?	☐ No ☐ Yes
If Yes, Medication and Time	
What other medications does the child take: Name/dosage/time	

Current School		Current Grade	
Classroom Setting	☐ Regular ☐ AS ☐ ES ☐ LS		
School Contact Name		Phone Number	
Support Plans	☐ IEP ☐ 504 ☐ Gifted IEP		

Does the child/adolescent 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				
Psychiatry/Psychologist				
☐MST ☐ FFT				
Partial Hospitalization (School Based/After School)				
Inpatient Hospitalization				
JPO				
OCY If so, why were they involved:				
Other - __________________				

Please state the reason for the referral to acute:

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Client/Family Strengths:
Client:____
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Family: ____
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Name of person completing this form:	
Relationship to child	
Phone number	
Signature	