

Children's Acute Partial Hospitalization Program Application

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

Name of ap	oplicant:					Date Completin Form:	g	
County of I	Residence:	Er	ie 🗌	Other:		Age:		
Race:						Gender:		
Date of Bir	th:					SSN:		
Parent/Gua contact:	rdian to					Home Phone:		
Address:						Work Phone:		
City, State,	Zip:					Cell Phone:		
Height/We	ight:					History of Suicidal Ideatio	n: Y N: explain:	
History of S Behaviors:		Expla	in:			History of Domestic Violence:	Y N: explain	
PARENT II	NFORMATION:	Father	,					
Name:					Home Pho	one.		
T tunic.	Last First			Cell phon				
Physical Address: Check if Same as Child, otherwise please provide below					Mailing Address: Check if Same as Physical, otherwise please provide below			
					pieuse pie			
Street Numb	er & Name	Ci	ty/State/Zip C	ode	Street Number & Name		City/State/Zip Code	
PARENT II	NFORMATION:	Mothe	r					
Name:	Last		First		Home Pho Cell Phon			
Last First Physical Address: Check if Same as Child, otherwise please provide below					Mailing Address: Check X if Same as Physical, otherwise please provide below			
	cuse provide below					preuse provide dell	,	
same Street Number & Name		same City/State/Zip Code		ode	Street Nur	nber & Name	City/State/Zip Code	

Last First Relationship Physical Address: Check if Same as Child, otherwise please provide below X Image: Check if Same as Child, otherwise please provide below X Street Number & Name City/State/Zip Code Phone Number: same () - (<i>Cell</i>) () - (<i>Cell</i>) (<i>Cell</i>) () - (<i>Cell</i>) (<i>Cell</i>) MA/Access Number Card Issue Number Funding CCBH HIPP Private Insurance Company 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 What other medications does the child take: Wat other medications does the child take: Yes	Name:								
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Current School			Current Grade	
Classroom Setting	Regular		ES	
School Contact Name			Phone Number	
Support Plans	IEP	504	Gifted IEP	
Does the child/adolescent c	urrently receive	any of the follow	ving services?	
	Current	Previous	Dates / Agency	Contact person/
	Current	Tievious	Dates / Agency	Phone Number
BHRS				
Blended Case Management				
Family Based Mental Healt	th			
Outpatient Therapy				
Psychiatry/Psychologist				
MST FFT				
Partial Hospitalization				
(School Based/After School	l)			
Inpatient Hospitalization				
JPO				
OCY				
If so, why were they				
involved:				
Other				
Γ				
Please state the reason for	r the referral to	acute:		

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