Barber Behavioral Health Institute

Children's Acute Partial Hospitalization Program Application

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

Name of Applicant:		Date:			
County of Residence:	☐ Erie ☐ Other:	Age:		Gender:	
Race:		Height/Weight:			
Date of Birth:		SSN:			
Address:		School:			
		Grade:			

GUARDIAN INFORMATION:			
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:		

GUARDIAN INFORMATION:			
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:		

Primary Insurance		Individual ID	
Name of Insured		Group ID	
Relationship to Applicant		Insured DOB	
Secondary Insurance		Individual ID	
Name of Insured		Group ID	

Does the child have a mental health diagnosis?	☐ Yes ☐ No		
Please list:			
Please attach a copy of the most recent psychological, psychiatric, or physician check-up indicating diagnosis if possible.			
Please list any chronic medical concerns (asthma, diabetes, etc…)			
Current Medications: (*include name, dosage, and presciber)*			
Current and Previous Providers and Therapies	**Medication Management**	C P	**Provider:**
	Behavior Services	C P	**Provider:**
	FFT/MST	C P	**Provider:**
	Children & Youth (OCY)	C P	**Provider:**
	Juvenile Probation	C P	**Provider:**
	Family Based (FBMH)	C P	**Provider:**
	Blended Case Mgt (BCM)	C P	**Provider:**
	Outpatient Therapy	C P	**Provider:**
Are any of the above therapies specialized (trauma, ASD, etc.)			

Current Concerns	
Suicidal Ideation	Describe (include any plans):
Suicidal Attempt	Describe:
Homicidal Ideation	Describe:
Self-harm/Self-destructive Behaviors	Describe:

Please state additional reasons for referral:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list additional persons (including contact information) to be contacted regarding intake:

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

Reminder: Please include releases when necessary.