Barber Behavioral Health Institute

Children's Acute
Partial Hospitalization Program
Application

Fax to Attn: Dr. Rochelle Von Hof 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:	
Address:		Phone:	
City, State, Zip Code:		Height/Weight:	
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:		

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

Does the child have a mental health diagnosis? ☐ No ☐ Yes	Attach one of the following: ***1.*** **Most recent psychiatric or psychological evaluation** ***OR*** ***2.*** **Letter stating child's diagnosis, date diagnosis given and who it was given by.**
Does the Applicant have any medical concerns? If yes, please note	☐ No ☐ Yes
Current Medications: Name/Dosage/Time	

Please state the reason for referral:

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

Reminder: Please include releases when necessary.