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:		Cell Phone:	
City, State, Zip Code:		Height/Weight:	

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 Applicant	
Individual ID		Group ID	
Insured Birth Day		Insured SSN	

Applicant's Current Diagnosis	
Date of Evaluation/Evaluator	
Does the Applicant have any medical concerns? If yes, please note	☐ No ☐ Yes
Current Medications: Name/Dosage/Time	

Please attach the most recent psychiatric or psychological evaluation with this referral form

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..