Barber Behavioral Health Institute

Children's Acute
Partial Hospitalization Program
Application

Fax to Attn: **Angela Watson** at (814) 833-0382

Name of Applicant		Date Completing form:	
County of Residence		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:

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

Reminder: Please include releases, when necessary.