Achievement Center's Summer Treatment Program Application

WARREN/FOREST COUNTY RESIDENTS

Child's Name ___________________________ Date ___________________________

Social Security #: ________________________ Date of birth _____________________

Age ____ Male: ___ Female: ____ Home Phone _____________________

Parent/Guardian _________________________ Work Phone _____________________

Address ________________________________ Cell Phone _____________________

____ Referral Source ___________________

Living Arrangements (if different): MA Card # _______________________

Name __________________________________ MA Card Issue # __________________

Address ________________________________ Insurance Group ___________________

____ Insurance ID# _____________________

Phone __________________________________

School District ___________________________ School Name ___________________________

School Contact Person _____________________ Grade ________________

IEP/Special Needs? Yes _____ No ______ Specify needs: __________________________

Other Agency Involvement (BHRS, OP, C&Y, Juvenile Probation, Drug & Alcohol, etc.)

Agency: _______________________ Contact Person ____________________ Phone ____________

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Mental Health Diagnosis (list) __________________ Diagnosis Given by _________________

____ Date of recent evaluation _____________

Describe Strengths : (Child's positive attributes, interests, etc.) ________________________

____

____

Describe Concerns: (Concerns in each environment and how long have they existed)

Home: ____

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School: ____

____

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Community : ____

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Other: ____

____

____

Behavior and Social (Complete brief summary for the following)

Peer Relations: ____

____

School Performance:____

____

Any special needs (physical, educational, dietary, etc.) ____________________________

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____

Medical History:

Current Medications: ____

Prescribing Physician: ____

What mental health services is your child currently receiving? _____________________

____

Agency: _______________ Contact Person: _________________ Phone: __________

Primary Care Physician __________________________ Phone _________________

Hereditary Disorders: ____

Allergies: ____

Medical Conditions: ____

Physical Limitations: ____

Birth History: (prenatal care, delivery complications, etc.) ___________________________

____

Developmental History (walking, talking, toilet training, etc.) ________________________

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What are your goals pertaining to you child being involved with STP? ________________

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What expectations do you have in regards to your child's experience in this program? ___

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Will you be able to attend weekly parent groups? Yes ____ No _____

- Children are expected to **attend all sessions**.
- The Program is therapeutic in nature and activities are designed and planned to maximize therapeutic impact using nationally recognized and standardized protocols.
- Parents need to be actively involved with daily consultation and weekly parent training.
- Referrals to more appropriate Mental Health Services may be recommended if indicated.

Signature ____________________________________ Date ________________________

Relationship to child: _______________________

Please send applications for Warren/Forest County residents to:

Achievement Center
Attn: STP Bill Kohler
414 Market Street
Warren, PA 16365