Elwyn/ ARCH of Lehigh Valley
2016 Summer Therapeutic Activities Program (STAP)

Thank you for your interest in Elwyn/ARCH of Lehigh Valley’s 2016 Summer Therapeutic Activities Program. ARCH’s Summer Therapeutic Activity Program is specifically for participants who have a diagnosis on the Autism Spectrum. This program is a therapeutic, highly structured summer day treatment service to address the social, emotional and behavioral difficulties associated with autism spectrum disorders. The STAP program will operate Monday -Friday, 9:00 am - 12:00 pm. Please review the dates that we will have program:
Thursday June 30th, Friday July 1st
No program Monday July 4th and Tuesday July 5th
Wednesday July 6th to Friday July 8th
Full weeks from Monday July 11th to Friday August 5th

To make a referral, please complete the attached referral packet and return to the ARCH. Packets can be mailed, emailed, faxed, or dropped off in person at the ARCH. Packets will be reviewed for admission on a first come first serve basis however, final acceptance into the program will be determined based on clinical review and medical necessity criteria. All participants will need to have a psychological evaluation or addendum prescribing the service and an ITM (team meeting) prior to submission to Magellan or DPW for authorization. More information will follow on this process. Acceptance into the program is not final until this process is complete.

Thank you again for your interest, please do not hesitate to contact me if there are any questions.

Sincerely,

Tonya Marsteller, MS/BCBA
Clinical Supervisor
610-573-2512
decimal: 610-573-2598
marstellert@elwyn.org
ARCH of Lehigh Valley
1347 Hausman Rd
Allentown, PA 18104
Referral Form

2016 Summer Therapeutic Activities Program (STAP)

Client's Name: ___________________________ DOB: __________ Age: _______
Social Security Number: ___________________ Access Card #: ___________________
Address: __________________________________ County: ___________________
Phone: ___________________________________

Does your child have medical assistance? Yes/ No
Does your child have private insurance coverage? Yes/ No
If yes, what carrier? _______________________

Please check phone number that you prefer to be reached at during regular business hours:

Parent/Guardian Name: ______________________

☑ Day Phone: ____________________________ Is this a work number? Yes/ No
☑ Cell Phone: ____________________________
E-mail address: _______________________________

Parent/Guardian Name: ______________________

☑ Day Phone: ____________________________ Is this a work number? Yes/ No
☑ Cell Phone: ____________________________
E-mail address: _______________________________

Emergency Contact other than parent/guardian:
Name: ____________________________ Phone: ____________________________
Relationship to child (ex: neighbor, relative, etc.): ____________________________

Child’s Primary Care Physician (PCP): ____________________________
PCP phone number: ____________________________
PCP Address: __________________________________

Person completing intake packet: ____________________________ Relationship to client: ____________________________
Phone #: ____________________________ Agency (if applicable): ____________________________
Reason for referral: __________________________________

________________________________________________________
________________________________________________________
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Clients Name: ___________________________ DOB: ___________________________

School Client Attends: _______________________ District: ___________________________

Phone: ___________________________ Contact Name: ___________________________

Classroom Placement (Autistic Support, Life Skills, etc.): ___________________________

Classroom ratio (teachers: students): _________

Grade: ___________ Special Education: YES NO (Circle one)

Extended School Year or Program name that child attended last summer: ___________________________

Service History: (i.e. early intervention, APS placement, etc.): ___________________________

Current Mental Health Services Received:

BHRS/Wraparound Provider: ___________________________

Case Manager (Name/Phone): ___________________________

BSC (Name/Phone): ___________________________

Other Mental Health Services Received (Outpatient, Family-Based, etc.):

Name of Provider: ___________________________ Type of Service: ___________________________

Staff/contact name/phone: ___________________________

Intensive or Blended Case management Services:

Provider Name/Phone number: ___________________________

Other services:

ID (Intellectual Disabilities) Supports Coordinator (Name/Phone): ___________________________

CYS (Children & Youth Services) Case Worker (Name/Phone): ___________________________

Does your child currently receive Speech Therapy? YES NO

Name of Provider: ___________________________ Speech Therapist: ___________________________
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Name: _______________________________  DOB: _______________________________

Communication

Please check all methods of communication that your child uses.

☐ Verbal  ☐ American Sign Language  ☐ Picture Cards/PECS
☐ Alpha talker  ☐ Gesturing/Pointing  ☐ Physically leading
☐ Other: ______________________________________

Is your child able to communicate independently using this method? Yes/ No
Please explain: ______________________________________

Socialization

When your child plays, he/she (check all that apply):

☐ Will share toys with a peer
☐ Will engage in play with a peer
☐ Will only engage in play with an adult
☐ Will approach another peer and engage peer in an activity
☐ Will not play with a peer but can tolerate peers playing in his/her “personal space”
☐ Will only play with a peer three or more years younger than him/herself
☐ Will only play with a peer three or more years older than him/herself
☐ Will not tolerate other peer(s) and will begin to cry
☐ Will not tolerate other peer(s) and hit adults
☐ Will not tolerate other peer(s) and will hit peer(s)
☐ Engages with age-appropriate items (i.e., videogames for a teenager, popular music, etc.)
☐ Engages with items that are not age-appropriate (items that would not typically interest same-aged peers, such as Barbie dolls for a teenager)
☐ Will imitate the play of another peer
☐ Will make up rules to a game and explain those rules to a peer
☐ Will understand verbal instructions and perform the correct play activity with peers, from those instructions
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Name: __________________________  DOB: __________________________

Behavior Assessment

My child (check any that apply):

Hits adults and/or peers, with an open hand (slap), at least:
  □ One time per day
  □ One time per week
  □ One time per month
  □ One time per year
  □ My child does not hit adults and/or peers

Hits adults and/or peers, with a closed hand (punch), at least:
  □ One time per day
  □ One time per week
  □ One time per month
  □ One time per year
  □ My child does not hit adults and/or peers

Bites adults and/or peers at least:
  □ One time per day
  □ One time per week
  □ One time per month
  □ One time per year
  □ My child does not bite adults and/or peers

Kicks adults and/or peers at least:
  □ One time per day
  □ One time per week
  □ One time per month
  □ One time per year
  □ My child does not kick adults and/or peers

Elopes (being at least three feet away from a designated area) at least:
  □ One time per day
  □ One time per week
  □ One time per month
  □ One time per year
  □ My child does not elope