Elwyn/ ARCH of Lehigh Valley
2017 Summer Therapeutic Activities Program (STAP)

Thank you for your interest in Elwyn/ARCH of Lehigh Valley's 2017 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:
Full weeks from Monday July 10th to Friday August 11th

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,

Adrienne Billmyer, MS, LBS
Clinical Supervisor
TSP/STAP
billmyera@elwyn.org
Elwyn/ARCH of Lehigh Valley
1347 Hausman Road
Allentown, PA 18104
Phone: 610-573-2500 ext. 42512

Referral Form

2017 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