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