Dear Parents,

Thank you for your interest in Elwyn/ARCH of LV’s 2010 Therapeutic Summer Camp Program! ARCH’s Summer Camp Program is for participants ages 11-21 who have a diagnosis on the Autism Spectrum. The camp will combine structure with fun games and activities designed to focus on improving social and communication skills. The camp will be held Monday - Friday 9:00 - 2:00 for 6 weeks beginning Wednesday, July 7th and ending on Tuesday, August 17th.

This year we will be offering a 7th week funded through private pay and/or alternative funding (not Medical Assistance). Please indicate on the forms if you would be interested in having your child attend an additional week.

To refer your child, please complete the 5 page referral packet and return to the ARCH. Parents have the option of mailing, e-mailing, faxing or dropping off the referral packets to the ARCH. Packets will be reviewed for admission on a first come first serve basis however, final acceptance into the program will also 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.

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

Sincerely,

Sarah Daniels
Therapeutic Program Coordinator
610-573-2505
fax: 610-573-2598
danielss@elwyn.org

ARCH of Lehigh Valley
Attn: Sarah Daniels
1347 Hausman Rd
Allentown, PA 18104
Elwyn/ ARCH of Lehigh Valley
Summer Therapeutic Activity Program (STAP)
Summer Camp

Admission Criteria

1. Child/Adolescent must be Medical Assistance eligible
2. Has a DSM-IV axis I diagnosis of Autistic Disorder, Pervasive Developmental Disorder NOS, or Asperger's Disorder
3. Is between the ages of 11 and 21 years
4. Medically stable; capable of having medications and treatment administered and monitored by camp staff
5. Child/Adolescent can participate with a 1:3 staff to camper ratio (possibility of 1:1 or 1:2 ratio dependent upon medical necessity and availability of staff)
6. Toileting skills through supervision, or at least be on a timed regiment to foster the skill

Exclusion Criteria

1. Behaviors of child may infringe on other camper programming
2. Fire setting (within past year)
3. History of multiple elopement within the past 6 months without a specific treatment goal to address elopement
4. Medical intensity exceeds administration greater than the program is capable of providing (This may be waived on a case by case basis, dependent upon medical supports provided by the private insurance company of the child's parents)
5. Has a pattern of inappropriate sexual behavior that cannot be addressed in a group setting and exceeds the level of care the program can provide
Referral Form
Therapeutic Socialization Program

Client's Name: ___________________________ DOB: ______________ Age: ______________
Social Security Number: __________________ Access Card #: ______________
Address: __________________________________ County: __________________________
Phone: _________________________________
E-mail address: __________________________ Does your child have medical assistance? ______
Does your child have private insurance coverage? ______ If so, what carrier? ______________

Please circle number that you prefer to be reached at during regular business hours:
Parent/Guardian Name: __________________________
Day Phone: __________________________ Cell Phone: __________________________

Parent/Guardian Name: __________________________
Day Phone: __________________________ Cell Phone: __________________________
Emergency Contact (Name/Phone): __________________________

Transportation:

____ I am interested in information about transportation to and/or from the summer camp program. 

****Please complete and sign attached form****

____ I am not interested in information about transportation to and/or from the summer camp program.

Additional 7th week:

____ Yes, I am interested in my child attending an additional week through private pay/alternative funding.

____ No, I am not interested in my child attending an additional week through private pay/alternative funding.

****Cost has not been determined at this time. Indicating interest in the additional week does not commit you to attendance and/or payment at this time. More information will follow.
Referral Form

Therapeutic Socialization Program

Name: ___________________________ DOB: ___________________________

School Client Attends: ___________________________ District: ___________________________

Phone: ___________________________ Contact Name: ___________________________

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

ESY or Program name that child attended last summer:

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

Current Mental Health Services Received:

Wraparound Provider: ___________________________
Case Manager (Name/Phone): ___________________________

BSC (Name/Phone): ___________________________

Outpatient Provider: ___________________________
Phone: ___________________________ Contact Name: ___________________________

Private Provider: ___________________________
Phone: ___________________________ Contact Name: ___________________________

Intensive Case Manager/Resource Coordinator (Name/Phone): ___________________________
Office of Mental Retardation Case Manager (Name/Phone): ___________________________
CYS Case Worker (Name/Phone): ___________________________

Referral Information:

Person completing intake packet: ___________________________ Relationship to client: ___________________________

Phone #: ___________________________ Agency (if applicable): ___________________________

Reason for referral: ___________________________

_________________________

_________________________
Referral Form

Therapeutic Socialization Program

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: ___________________________

Socialization

Please describe your child’s ability to engage/interact in groups settings (ie. Parallel plays, approaches others, tolerates small groups of similar age children, etc):

__________________________________________________________

Please describe your child’s challenges in group settings:

__________________________________________________________

Behavior Awareness

Please explain circumstances when your child may exhibit the following behaviors. Include how many times per day your child does this behavior on average.

☐ Head bangs hand to head (x’s/day ____) when ____________________________

☐ Head bangs head to object [wall/desk/etc] (x’s/day ____) when ____________________________

☐ Hand/wrist bites (x’s/day ____) when ____________________________

☐ Pinches self (x’s/day ____) when ____________________________

☐ Pinches others (x’s/day ____) when ____________________________

☐ Scratches self (x’s/day ____) when ____________________________

☐ Scratches others (x’s/day ____) when ____________________________

☐ Hits others (x’s/day ____) when ____________________________

☐ Bites others (x’s/day ____) when ____________________________

☐ Wanders/elopes (x’s/day) when ____________________________

☐ Other ____________________________________________
Referral Form

Therapeutic Socialization Program

Name: ___________________________ DOB: ___________________________

Medical Concerns

Allergies:
☐ Medication allergies: __________________________________________________

☐ Food allergies: _______________________________________________________

☐ Environmental allergies: _____________________________________________

☐ Other: ______________________________________________________________

Seizures:
Triggers: _____________________________________________________________

Date of last seizure: ___________________________________________________

How often do seizures occur? ___________________________________________

Adaptive devices used:
☐ Glasses
☐ Right hearing aid
☐ Left hearing aid
☐ Other ___________________________

Mobility

☐ Walks independently
☐ Walks with assistance
☐ Walks with cane/walker
☐ Walks with unsteady gate

☐ Uses wheelchair
☐ Uses protective headgear (when _______________________

☐ Other ___________________________

Self Care

☐ Independent toilet skills
☐ Limited toilet skills
☐ successful with timed schedule
☐ independent urinary ability
☐ will assist with bowel movement/clean up
☐ diapers worn but will use toilet with prompting/assistance

☐ Independent dresser
☐ Needs assistance with dressing
☐ buttoning
☐ zippering
☐ shoes on correct feet
☐ tying shoes

☐ Able to identify own backpack
☐ Can change into bathing suit without assistance
Referral Form
Therapeutic Socialization Program

Name: __________________________  DOB: __________________________

Sensory Sensitivities
Please describe your child’s sensitivities/needs in the following areas:

Visual (bright light, sunlight, indoor lighting, “busy” room décor, etc):
________________________________________________________________________
________________________________________________________________________

Hearing/sounds (fire alarms, telephones, blenders, soft sounds, etc):
________________________________________________________________________
________________________________________________________________________

Touch (light touch, heavy touch):
________________________________________________________________________
________________________________________________________________________

Balance/movement (jumping, swinging, moon bounce, swimming, etc):
________________________________________________________________________
________________________________________________________________________

Taste/smell (sour, sweet, salty, mint, perfumes, soaps, etc):
________________________________________________________________________
________________________________________________________________________

Other sensory sensitivities:
________________________________________________________________________
________________________________________________________________________

Fears/anxieties:
________________________________________________________________________
________________________________________________________________________
Amy Breininger

From: Patricia Theodore
Sent: Thursday, April 01, 2010 9:22 AM
To: Amy Breininger
Subject: FW: ARCH summer Camp Forms

Amy - I don't know if you already have this information or not.
If you do, disregard this e-mail - Pat

From: Kimberly McFarland [mailto:Kimberly_McFarland@elwyn.org]
Sent: Wednesday, March 31, 2010 4:19 PM
To: Kimberly McFarland
Cc: Ellen Hunt; Emily C. Leayman; Stacey Sweeney; Sarah Daniels; Jason Lewis; Kimberly M. Steltz; Scott Lesko; Kelsey Arcelay; Robin L. Urenko; Karen L. Johns; Krista Malone; Connie R. Davco; jrzurenko@aol.com
Subject: ARCH summer Camp Forms

ARCH 2010 Camp referral packets are available! Please contact
Sarah Daniels if you are interested in receiving a referral packet.

To refer your child, you will need to complete the 5 page referral packet and return to the ARCH. Parents have the option of mailing, e-mailing, faxing or dropping off the referral packets to the ARCH. Packets will be reviewed for admission on a first come first serve basis however, final acceptance into the program will also 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.

Sarah Daniels
Therapeutic Program Coordinator
610-573-2506

fax: 610-573-2508

danielss@elwyn.org

ARCH of Lehigh Valley
Attn: Sarah Daniels
1847 Hausman Rd

4/6/2010
ARCH of LV
2010 Therapeutic Summer Camp Program
Transportation Needs Form

Participants Name: ___________________________ DOB ____________

Medical Assistance (MA) Eligible: Yes or No

Please check the following that applies:

______ Parent/Guardian is able to provide transportation to the program and file for mileage reimbursement.

______ Parent/Guardian is unable to provide transportation to the program. MA funded door-to-door services are requested for the participant.

If you are requesting transportation for the participant to the program please state reason for request (i.e. work schedule, pick-up/drop off of other children).

___________________________________________________________________________

___________________________________________________________________________

Please check the following that applies:

______ Parent/Guardian is able to provide transportation from the program and file for mileage reimbursement.

______ Parent/Guardian is unable to provide transportation from the program. MA funded door-to-door services are requested for the participant.

If you are requesting transportation for the participant from the program please state reason for request (i.e. work schedule, pick-up/drop off of other children).

___________________________________________________________________________

___________________________________________________________________________

Parent/Guardian Signature: ___________________________ Date: _______
ELIGIBILITY FORM

SECTION 1 - HOUSEHOLD IDENTIFYING INFORMATION
NAME (Last, First, MI)                            DATE OF BIRTH       TELEPHONE NUMBER
ADDRESS (Street, City, Town, State, Zip Code)    COUNTY OF RESIDENCE

SECTION II - MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/REVERIFICATION
MATP FUNDING STATUS □ GROUP I □ GROUP II ID-00, D-05, B-00, PD-00, PD-21, PD-22, PD-29, 
TD-00, TD-11, TB-00
ACCESS CARD INFORMATION □ RECIP NUMBER
SOCIAL SECURITY NUMBER
CARD ISSUE NO.
EVIS ELIGIBILITY INFORMATION
DATE OF SERVICE
HEALTH CARE BENEFIT CODE
PROGRAM STATUS CODE
CATEGORY OF ASSISTANCE
PLAN_NAME
HOTLINE NUMBER
LOCK IN INFO

OTHER ELIGIBLE HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>NAME</th>
<th>RECIPIENT NUMBER</th>
<th>SSN</th>
<th>STATUS</th>
<th>DOB</th>
<th>GRP</th>
<th>MODE</th>
<th>FREQ/Wk-Mo</th>
<th>SPEC. NEED</th>
</tr>
</thead>
</table>

MODE KEY
P = Public Transit  S = Shared Ride  A = Private Auto  V = Volunteer  O = Other (See Svc. Notes)

SECTION III - DETERMINATION OF NEED FOR SERVICES
OTHER FUNDING SOURCES □ PENNDOT 203 □ DEPARTMENT OF AGING □ OTHER (Explain)

SPECIAL NEEDS
MODE

OTHER INFORMATION/ SERVICE NOTES

SECTION IV - ELIGIBILITY DETERMINATION DECISION
ELIGIBILITY STATUS □ ELIGIBLE □ INELIGIBLE
DATE CLIENT NOTIFIED
DATE ELIGIBILITY DETERMINED

INELIGIBLE (Explain)

SECTION V - AFFIRMATION OF INFORMATION
I hereby certify, that, to the best of my knowledge, the information contained herein is true, correct and complete. I agree to report any changes in circumstances immediately to this Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Public Welfare fair hearing. This affirmation statement covers all attachments required for the determination of eligibility.

SIGNATURE OF CLIENT OR DESIGNEE       DATE SIGNED       SIGNATURE OF INTERVIEWER       DATE SIGNED

EXHIBIT 2

SP 890 - 2/98