Stepping Forward Counseling Center LLC

We teach the mind to think, the hands to work, the heart to love.

Therapeutic Summer C.A.M.P.

Clinically Advanced Multi-Modality Program

Application For (Check One):

☐ Chatham, NJ ☐ Yorba Linda, CA ☐ Irvine, CA

Contact & Background Information:

Last Name of Child:_____ First Name of Child:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ DOB:_____ Age:_____ Gender:_____

Child Lives With (check one):

☐ Mother ☐ Father ☐ Both ☐ Other

If divorced, or legally separated, who has custody?_____

Parent/Guardian 1 Information:

Last Name:_____ First Name:_____ DOB:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Work:_____

Email Address:_____ Relation to Child:_____

Parent/Guardian 2 Information:

Last Name:_____ First Name:_____ DOB:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Work:_____

Email Address:_____ Relation to Child:_____

Emergency Contact Information:

Last Name of Emergency Contact:_____ First Name of Emergency Contact:_____

Home Phone:_____ Cell:_____

Relation to Child:_____

Last Name of Emergency Contact:_____ First Name of Emergency Contact:_____

Home Phone:_____ Cell:_____

Relation to Child:_____

Special Requests: Please list ALL allergies and special dietary needs that pertain to your child.

_____

_____

Medications: Please list ALL the names and dosages of your child's prescribed medications. Inform SFCC immediately of any changes.

_____

_____

22343 La Palma Ave, Suite 116, Yorba Linda, CA, 92887 • **P** 714.340.0511 • **F** 714.340.0552
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PROGRAM DATES

Day Camp Dates (CHATHAM, NJ): Please check the dates your child will be attending.

☐ 22 June - 26 June ☐ 29 June - 03 July ☐ 06 July - 10 July ☐ 13 July - 17 July ☐ 20 July - 24 July

☐ 27 July - 31 July ☐ 03 August - 07 August ☐ 10 August - 14 August ☐ 17 August - 21 August

☐ 24 August - 28 August

Day Camp Dates (YORBA LINDA, CA): Please check the dates your child will be attending.

☐ 15 June - 19 June ☐ 22 June - 26 June ☐ 29 June - 03 July ☐ 06 July - 10 July ☐ 13 July - 17 July

☐ 20 July - 24 July ☐ 27 July - 31 July ☐ 03 August - 07 August ☐ 10 August - 14 August

☐ 17 August - 21 August

Day Camp Dates (IRVINE, CA): Please check the dates your child will be attending.

☐ 08 June - 12 June ☐ 15 June - 19 June ☐ 22 June - 26 June ☐ 29 June - 03 July

☐ 06 July - 10 July ☐ 13 July - 17 July ☐ 20 July - 24 July ☐ 27 July - 31 July

☐ 03 August - 07 August ☐ 10 August - 14 August ☐ 17 August - 21 August

• Please note pick up times may vary, so please check the field trip schedule.

Additional Services: Please check services required for your child (additional fees will apply).

☐ Early drop off ($15/hour, 8:00AM - 9:00 AM) ☐ Late pickup ($15/hour, 4:00PM - 6:30 PM)

Drop off time_____ Pickup time_____

T-Shirt Information: Please check size for the **FREE T-Shirt** for summer of 2020 (Predict size in summer)

☐ YS ☐ YM ☐ YL ☐ AS ☐ AM ☐ AL ☐ AXL ☐ A2XL

Additional T-Shirts may be purchased for $20 each.

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FINANCIAL INFORMATION

Published rates are for Cash and Schools only. Other institutions are billed at a higher rate. Client is ultimately responsible for payment of all charges identified as "due amounts" which include: insurance payments forwarded to client; co-payments, intake fees, reinforcement fees, missed appointment fees; application fees and other fees and costs delineated by SFCC. SFCC shall submit applicable due amounts (identified as "insurance billed amounts") for reimbursement to client's insurance provider. Failure to pay insurance proceeds received by member shall be subject to collection by SFCC with client being responsible for all costs of collection, including attorney fees. Stepping Forward owns and operates licensed and/or accredited mental health treatment centers and therapeutic summer programs. The length of stay and level of clinical intervention determine the cost of each program. Tuition/fees may range from $225.00 to $65,000.00 and may be supplemented by sliding scale, insurance, scholarships, or payment agreements. Many of our programs are contracted with insurance carriers, scholarships and school programs. Parents are encouraged to contact SFCC directly to request assistance with obtaining payments and insurance coverage.

SCHOOL REIMBURSEMENT

School District Contact Name/Title:_____

School District Contact Phone:_____ School District Contact Fax:_____

IEP (check one): ☐ Yes ☐ No

INSURANCE INFORMATION

MEMBER NAME_____

MEMBER DOB_____

Please submit insurance information

Child's Name:_____ Date of Birth:_____

Carrier Name:_____ Policy Number:_____

Effective Date:_____ Insurance Provider Phone Number:_____

CREDIT CARD/CHECK INFORMATION

***Your application will not be processed until the fee is received.**

Please note that the $300.00 processing fee must be included with the application.

Enclosed is my (check which apply)

☐ Check (Amount): _____ **and/or** ☐ Visa ☐ MasterCard ☐ American Express (Amount): _____

Card Number:_____ Security Code:_____ Expiration:_____

Billing Address:_____ City:_____ State: _____ Zip: _____

Cardholder's Name:_____

Signature_____

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ENROLLMENT QUESTIONNAIRE - COUNSELOR'S INSIGHT

Please Provide the Important Information Below:

1. Case Manager Name/Title (If Applicable): _____

Phone: _____ Child's School District: _____

2. Please describe your child's school setting and goals: _____

_____

_____

_____

3. What is your child's educational classification? _____

_____

4. What is your child's diagnosis? _____

_____

5. Please list and describe your major concerns for your child. _____

_____

_____

_____

6. Is your child physically aggressive? ☐ Yes ☐ No Does your child bite? ☐ Yes ☐ No

7. Has your child ever been asked to leave a program? If so, please explain: _____

_____

_____

_____

8. Do you consider your child more compliant or more oppositional? Please explain: _____

_____

_____

_____

9. Please describe your child's attention span: _____

_____

_____

10. Please describe your child's language ability: _____

_____

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11. Please name and explain activities and areas of greatest success for your child: _____

_____

_____

_____

12. Please describe previous summer camp experiences your child has had (be sure to include dates and place/name of camp):

_____

_____

_____

_____

13. Under what circumstances, if any, does your child become stressed or frustrated? _____

_____

14. Is there a "nickname" your child likes to be called? _____

15. Is there anything you feel we need to know about your child? _____

_____

_____

Strengths: _____

_____

Weaknesses: _____

_____

16. What is your child's swimming experience? Check one:

☐ Needs to learn ☐ Wears floaters ☐ A novice ☐ Has experience ☐ Swims in the deep end

17. What are your child's fears? _____

_____

18. Please name activities your child would most enjoy at Stepping Forward: _____

_____

19. Please state YOUR requested goals for your child at Stepping Forward: _____

_____

_____

_____

_____

Decision for formal enrollment to program is based upon personal interview, observation and review of supportive information, after receiving the completed application and processing fee of $300.
Please call your local Stepping Forward (973) 635-6550 as soon as possible to set up an appointment.

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Clinically **A**dvanced **M**ulti-Modality **P**rogram

PARENT AUTHORIZATION

1. I agree to pay the annual tuition. Pre-payment is due prior to the start of camp. In the event of checks being received from third party payment, all claims are due to Stepping Forward Counseling Center, LLC. In the event a check(s) is/are received from an insurance provider and/or school, it is agreed that said check(s) will be designated as "payable to Stepping Forward Counseling Center" and the check(s) and explanation of benefits will be immediately forwarded to Stepping Forward.

2. No refunds will be made for incidental absences or after camp has started.

3. Stepping Forward is not responsible for any camper's belongings, either lost or damaged, while attending.

4. If either parent or the emergency contacts cannot be contacted in an emergency, I hereby give Stepping Forward consent to bring my child to an emergency room or medical professional and authorize Stepping Forward to provide consent to secure necessary and proper medical treatment. I authorize and direct Stepping Forward to administer medication as set forth in this application.

5. Permission is hereby granted to the Directors of Stepping Forward to take my child on field trips as part of the regular program.

6. Permission is hereby granted for photographs to be taken of my child during activities and Stepping Forward has the right to utilize these photographs in promotional materials.

7. My child has permission to engage in all prescribed program activities, except as noted on the required medical form.

8. Permission is hereby granted to Stepping Forward to transport my child to and from any off-site activities.

9. Permission is hereby granted to Stepping Forward counselors to apply sunscreen to my child.

Child's Name: _____

Parent/Guardian Signature: _____ Date: _____

Non-Custodial Parent/Guardian Signature: _____ Date: _____

CHECKLIST

_____Enclose a photo of your child (For safety reasons)

_____Sign parent authorization & Medical consent form

_____Child immunization record sent with application

_____Enclose payment $300.00 to hold space

_____Make a copy of application for your records

_____Record summer program dates on your calendar

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Individual Program Planning Dates

(For Office Use Only)

Child's Name: _____

Intake / Evaluation

Date: _____ Time: _____

Parent Session

Date: _____ Time: _____

Progress / Follow Ups

Date: _____ Time: _____

Exit / Evaluation

Date: _____ Time: _____

Medical Treatment Consent Form

As the parent/guardian of: _____

I give my consent for Stepping Forward Counseling Center to take any medical emergency treatment precautions necessary in case of injury or illness to ensure the safety of my dependent. I give permission for SFCC to provide first aid and to contact the Emergency Medical Service to transport my dependent to the nearest hospital in order to treat him/her with serious injury and/or illness while on-site, or on off-site trips.

Signature of parent/guardian: _____

Special Requests

Please list ALL special needs that pertain to your child: _____

_____

_____

_____

_____

_____

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Child Immunization Record

To be completed by Physician's office.

Child's Name:_____ Date of Birth:_____

Parent/Guardian Name:_____

MEDICAL CONTACT INFORMATION

Pediatrician's Name:_____ Psychologist's Name:_____

Psychiatrist's Name:_____

Health Comments

Diabetes ☐ Yes ☐ No Asthma ☐ Yes ☐ No

If yes to either of the preceding questions, please list special instructions in the space below:

_____

_____

_____

_____

Diet (Check one):

☐ Poor ☐ Fussy ☐ Needs Improvement ☐ Average ☐ Good ☐ Healthy

Vaccinations:

☐ Diptheria ☐ Tetanus ☐ Pertussis Date Given: _____

If TD or DT please indicate: _____ Date Given: _____

Last Date of Tetanus Shot: _____

☐ Polio Virus Vaccine Date Given: _____

☐ Pneumococcal Vaccine Date Given: _____

☐ Hepatitus B Vaccine Date Given: _____

☐ Haemophilus B Vaccine Date Given: _____

☐ Varicella (Chicken Pox Vaccine) Date Given: _____

☐ MMR (Measles, Mumps, Rubella) Date Given: _____

☐ Other: _____ Date Given: _____

Provisional Admission: ☐ Yes ☐ No Date Given: _____

Medical Exemption: ☐ Yes ☐ No Religious Exemption: ☐ Yes ☐ No

Additional Notes:_____

_____

_____