



# Stepping Forward Counseling Center LLC

## 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.

\_\_\_\_\_



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### PROGRAM DATES

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

- 27 June - 01 July    05 July - 08 July    11 July - 15 July    18 July - 22 July  
 25 July - 29 July    01 August - 05 August    08 August - 12 August    15 August - 19 August  
 22 August - 26 August

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

- 20 June - 24 June    27 June - 01 July    05 July - 08 July    11 July - 15 July    18 July - 22 July  
 25 July - 29 July    01 August - 05 August    08 August - 12 August    15 August - 19 August  
 22 August - 26 August

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

- 06 June - 10 June    13 June - 17 June    20 June - 24 June    27 June - 01 July  
 05 July - 08 July    11 July - 15 July    18 July - 22 July    25 July - 29 July  
 01 August - 05 August    08 August - 12 August    15 August - 19 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 (\$20/hour, 8:00AM - 9:00 AM)    Late pickup (\$20/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 2022 (Predict size in summer)

- YS    YM    YL    AS    AM    AL    AXL    A2XL    A3XL    A4XL

**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 \$400.00 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 \$400.00 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 \$400.**

**Please call your local Stepping Forward as soon as possible to set up an appointment.**

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

26 Main Street, Chatham, NJ, 07928 • P 973.635.6550 • F 973.635.6555

15375 Barranca Parkway, Building D, Irvine, CA 92618 • P 949.333.1209 • F 949.333.1208

[www.SteppingForwardCounselingCenter.com](http://www.SteppingForwardCounselingCenter.com)



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### 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 \$400.00 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: \_\_\_\_\_



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## 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:

Diphtheria    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: \_\_\_\_\_

Hepatitis B Vaccine   Date Given: \_\_\_\_\_

Haemophilus B Vaccine   Date Given: \_\_\_\_\_

Varicella (Chicken Pox Vaccine)   Date Given: \_\_\_\_\_

MMR (Measles, Mumps, Rubella)   Date Given: \_\_\_\_\_

COVID-19 Vaccine   Date Given: \_\_\_\_\_

Other: \_\_\_\_\_ Date Given: \_\_\_\_\_

Provisional Admission:  Yes    No   Date Given: \_\_\_\_\_

Medical Exemption:  Yes    No   Religious Exemption:  Yes    No

Additional Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_