REFERRAL FORM

Client Name:

Parent or legal guardian:

(Name)

(Address) (city) (state) (zip)

Parent/Legal Guardian email:

Are parental rights terminated? Mother YES ☐ NO ☐ Unsure ☐ Father YES ☐ NO ☐ Unsure ☐

If unsure, please explain:

Current Placement:

Contact information to set up intake assessment

Phone Number

Email Address

Medicaid# **Social Security#** **Trails ID#**

In addition to Medicaid, does this youth have any other health insurance? YES ☐ NO ☐

If yes, please specify the provider. If the youth has Medicaid through CHP+, please indicate.

Is this youth eligible for Youth in Transition? YES ☐ NO ☐ Unsure ☐

If yes, dates the youth was in DHS custody

Has the client had a prior Third Way Center placement? YES ☐ NO ☐ Unsure ☐

Legal Status:
☐ D&N ☐ Adjudicated ☐Parole ☐Pending Charges ☐Previous Charges ☐Committed ☐Probation ☐N/A

Caseworker/Client Manager:
Name email Phone

PO Name & Contact Information:
Name email Phone

GAL Name & Contact Information:
Name email Phone

Number of hospitalizations: **Why?**
☐ Suicide Attempts ☐ Suicidal Ideation ☐ Medical ☐ Danger to Others

Current Medication(s):

For Mental Health Partnering Pay Sources: Youth is approved by their home school district for school at the PRTF, QRTP, or RCCF level of care. YES ☐ NO ☐

Are there any contact restrictions? YES ☐ NO ☐

If yes, please list restrictions:

Additional Contacts:

Relationship	Name	email	Phone

Your referral will not be considered complete unless all of the documents are included. Please make certain that you include the following:

- ☐ Trails ID
- ☐ Birth Certificate copy
- ☐ Social Security Card or number
- ☐ Medicaid numbers
- ☐ Independent Assessor Report, if available (Required for QRTP placement)
- ☐ Psychological/Neuropsychological Evaluations and all testing, including IQ/IEPs
- ☐ Placement history and discharge summaries from previous placements
- ☐ Family Treatment/ Service Plan
- ☐ Any medical information that may pertain to their mental health
- ☐ Current Medication Administration Record
- ☐ Health Passport (date of last physical, dental, vision and immunization records)
- ☐ Legal History
- ☐ Insurance cards for primary and secondary insurance.
- ☐ If youth is offense specific; offense specific evaluation, previous treatment records

Please place an X next to each item above to indicate that it is included in your submission. If anything is not included, please explain in the comment box below.

Send the above paperwork to Third Way Center via email to referrals@thirdwaycenter.org

Comment: