



Human Services &  
Community-Based Programs

## Children and Family Treatment Support Services Referral Form

Date: \_\_\_\_\_

### Child/Youth's Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Gender: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medicaid CIN: \_\_\_\_\_ Managed Care Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Best time to contact family regarding this referral: \_\_\_\_\_

### Referral Contact Information:

Referring Agency or Provider: \_\_\_\_\_

Referral Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*\*Current providers, please attach last comprehensive assessment or treatment plan.*

### Client History:

Diagnosis: \_\_\_\_\_

Presenting concerns: \_\_\_\_\_

Goals for Treatment: \_\_\_\_\_

Current medications: \_\_\_\_\_

Currently receiving clinical therapy? If yes, provider name: \_\_\_\_\_

Other providers working with client (PCP, School, DSS, Community Based Organizations, etc.):

*\*Please email referral to:*

**Elizabeth Zeigler at [tcpr@chjc.org](mailto:tcpr@chjc.org)**

Determination of services will be shared with the referral source contact listed above. If you have any questions, please call Elizabeth Zeigler at (315) 777 -9642.