*** Specialized Therapeutic Group Care Referral Form***

Please complete this form in its entirety and return to Avidity by email to stgc@avidity.org.

***IMPORTANT NOTE: Avidity no longer operates a STGC facility for boys.*** *We will only accept referrals for young women ages 13-17 who have experienced sexual trauma.*

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**Youth Referred**

**First Name:**Click or tap here to enter text. **Last Name:** Click or tap here to enter text.

**DOB:**mm/dd/yyyy **SSN:** ### - ## - ####

**Address (Street Address, City, State, ZIP):**

Click or tap here to enter text.

**Gender:** Click or tap here to enter text.

**Foster Care**  **Community Youth** *If yes for Foster Care*:

**Lead Agency**: Click or tap here to enter text.

**Case Management Agency**: Click or tap here to enter text.

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**Individual Making Referral**: Click or tap here to enter text.

**Agency**: Click or tap here to enter text. **Position**: Click or tap here to enter text.

**Phone #**: Click or tap here to enter text. **Alt. Phone#**:Click or tap here to enter text.

**Email**: Click or tap here to enter text.

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**Legal Guardian Name**: Click or tap here to enter text.

**Relationship to Person Referred**: Click or tap here to enter text.

**Legal Guardian Address: Same as Person Referred?** Yes No *If no, list Legal Guardian address*:

Click or tap here to enter text.

*Street Address Apt. City, State ZIP*

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**Additional Contact**: Click or tap here to enter text.

**Relationship to Person Referred**: Click or tap here to enter text.

**Phone#:** Click or tap here to enter text. **Other Phone#**: Click or tap here to enter text.

**Emergency Contact**: Click or tap here to enter text. **Phone#**: Click or tap here to enter text.

**Relationship to Person Referred**: Click or tap here to enter text.

**Is Person Referred in School?:** Yes  No *If yes, Name of School:* Click or tap here to enter text.

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**Youth’s Current Placement:**

Group Home Shelter  SIPPFoster Home Therapeutic FH Bio Family

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**Limited English Proficiency?:** Yes No *If yes, who?*:  Person Referred Other

**Preferred Language for Assessment**:Click or tap here to enter text.

**Preferred Language for Services**: Click or tap here to enter text.

**Other accomodations**:  Visually Impaired  Hearing Impaired

*Auxiliary Communication Aids desired?:* Click or tap here to enter text.

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**Race**:  White Hispanic American Indian Alaskan Native White Non-Hispanic

Multi-Racial Asian or Pacific Islander Native Hawaiian African American

Hispanic of African American Descent Other: Click or tap here to enter text.

**Ethnicity**:Puerto Rican Mexican Cuban Other Hispanic Haitian

None of these

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**Insurance/Funding**: Click or tap here to enter text.

**Policy/Member ID**: Click or tap here to enter text.

Medical/psychological diagnoses:

Click or tap here to enter text.

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*Required Documents that must accompany this referral*: \*Current Suitability Assessment \*Current DJJ Face Sheet \*Letter from a Psychiatrist stating the need for STGC Specialized Treatment (*Community Youth Only*)

*Factors that may impact acceptance into these treatment programs*: \* Autism \*Intellectual Disability \*Untreated Psychosis \*Active Substance Use \*Frequent Elopements \*Weapons charges

Name & Title of Person Completing Form:

Click or tap here to enter text.

MM/DD/YYYY

E-Signature **DATE**

*Please send the completed referral form to Avidity by email at stgc@avidity.org*