elevate YOUTH SERVICES

Referral Form

Please email completed referral to: **referrals@elevateyouthvt.org**

Legal Name **DOB:**

SS# **Gender:**

Insurance Provider **DCF Family #:**

Address

Youth Contact Info

Home: **Cell:**

Email Address:

Is it ok to Identify ourselves when leaving a message on any of the above forms of contact? Yes No

Emergency Contact Info

Name: **Relationship:**

Home: **Cell:**

Email Address:

Is it ok to Identify ourselves when leaving a message on any of the above forms of contact? Yes No

Person Providing Info

Name: **Relationship:**

Phone: **Email:**

Referral Information

Today's Date: **Are Services Mandated?** Yes No

Current Living Situation: Home, Foster Home, Residential, Friend, Independent, Homeless, Runaway, **Other:**

Does youth have a stable living situation at the time of referral? Yes No

Are any other agencies/ providers involved?

Does youth feel safe in their current living situation? Yes No

Last Grade Completed:
Enter Grade or comments to the right

Is youth attending school Regularly? Yes No

Employment Status: Employed Part Time, Employed Full Time, Unemployed Looking for work, Unemployed Not Looking for work, Not in Labor Force, **Other:**

Is youth or partner currently pregnant or parenting? Yes No

Reason for Service Request

What is the best way to get in contact with client to schedule appointment? Youth Contact Info, Emergency Contact Info, Person Providing Information

When is the best time to meet with this individual? Day(S) Time(S)

Reset Form

PRELIMINARY RELEASE OF INFORMATION

I, _____ **born on this date**_____
(Name of person whose information is being requested)

Authorize: Elevate Youth Services

To communicate with: _____

_____

_____

Regarding **appointment scheduling and attendance status** regarding my engagement with Elevate Youth Services in written, oral and electronic methods. I understand that this authorization will expire 30 days from the date signed below.

I understand that federal regulations (42 CFR.part2) prohibit the re disclosure of drug & alcohol treatment information without my written consent or as allowed by the regulations. I understand that under Vermont statute, my health Information can only be disclosed with my authorization or as mandated by an express provision of law. For disclosures of information made to organizations outside of the State of Vermont, all other health information used or disclosed pursuant to the authorization may be subject to re disclosure by the recipient and no longer protected this rule (Privacy Standards of the Health Insurance Portability and Accountability Act of 1996).

I understand that my treatment/ support is not conditioned upon authorizing this disclosure. I understand I may revoke this authorization at any time except to the extent that the Agency, or other agency making the disclosure, has already acted in reliance on it. In general revocation should be submitted in writing and sent to the Agency at the address below.

Client's Signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

Witness' Signature: _____Date: _____