Center for COMMUNITY ALTERNATIVES

Youth REFERRAL FORM

DATE: _____/_____/_____

Medicaid CIN#: _____

LAST NAME: _____ FIRST NAME:_____ DOB: _____

ADDRESS: _____ ZIP:_____

PHONE: _____ CELL: _____

Eligibility Requirements:

□ Live in Monroe County □ Between the ages of 12-17 □ Identify as having an opioid or stimulant misuse history □ Have or at risk of having a legal history (including those in school, expelled, returning from detention, or homebound)

REASON FOR REFERRAL:

_____

_____

_____

_____

_____

Participant Signature _____
Date_____

Parent Guardian Signature _____
Date_____

Name of person completing referral

_____

FOLLOW-UP OUTCOME:

_____