



TEEG
 P.O. Box 664
 65 Main Street
 North Grosvenordale, CT 06255
 (860) 923-3458 / Fax 860-923-5770

2010 ASAP Referral Form

Date: _____ Referral Source: DCF Probation School CHR

Contact Name: _____ Phone: _____

Client information

Client Name: _____ DOB _____ Age: _____ M F

Address: _____

Living Situation: Parent/s Foster home Residential Group home Other

Primary caretaker: _____ Relationship: _____

Legal Guardian: _____ Phone: _____

Legal Status: OTC DCF custody TPR FWSN Voluntary N/A

Social Worker: _____ Phone: _____

Supervisor: _____ Phone: _____

Reasons for referral (why traditional camp program is not appropriate at this time) Please include high risk behaviors, mental health diagnosis, and/or medications:

Provider Funding Authorization

I agree to provide payment in the amount of \$ 2,700 for _____ to attend one full session of TEEG'S 2010 All Star Adventure Program. I understand the fee is nonrefundable in case of cancellation or failure to attend.

I have received and reviewed the 2010 ASAP application packet and I am aware that it must be completed and submitted before June 25, 2010 to ensure enrollment in this program.

Provider Signature _____ _____
Title _____ _____
Date

Contact Person: Lori Britto, Program Director Phone: 923-3458 Fax: 923-5770

