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

TSS/SS REFERRAL FORM

Date of Referral: ____________

Referral Source Name: __________________________ Agency:__________________________________

Phone: __________________________ Fax:____________________ Email: ________________________

Client name:_____________________________ DOB__________ Age:_____ Gender: ❑ M ❑ F

Residing address: ____

Type of Residence: ❑ Parent/s home ❑ Foster home ❑ Residential/Group home ❑ Other

Reason for referral (presenting problem , individual and family needs):_______________________________

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Please note any high risk behaviors, mental health diagnosis, and/or medications: ________________________

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Parent/Guardian name(s)_________________________________ Relationship:____________________

Address (if different) ____

Phone: (home) ________________________ (cell) __________________(other):____________________

School:____________________________ Grade:____ Special Education: □Y □N □504

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

Social Worker :___________________________ Phone: _______________________ Fax:______________

Supervisor: _______________________________ Phone: _______________________

Area Office: ❑ Norwich ❑ Willimantic ❑ Other _______________ CHILD LINK #:__________________

Other providers involved: ____

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To complete the referral process and schedule an intake assessment, please submit the following signed authorization to Kelly Piper, TSS/SS Program Manager

TEEG will conduct an in-home Comprehensive Program Assessment at the child's current residence, which will include interviews with the child and significant family members, collaboration with other providers and an evaluation of the family needs. If TEEG's services are deemed appropriate for the child, a goal-oriented child specific treatment plan will be submitted to the referral agency along with a financial contract for approval.
I approve the expenditure of $400.00 to TEEG for a TSS/SS Program Assessment.

Authorizing Person:____ Date:____________
Signature Title