THOMPSON ECUMENICAL EMPOWERMENT GROUP

P.O. BOX 664, 15 Thatcher Rd. NORTH GROSVENORDALE, CT 06255
(860) 923-3458 Fax 860-923-5770 www.teegonline.org

TSS/SS Referral Form

Date of Referral: _____

Referral Source: _____

Contact Name: _____Phone: _____

Client Information

Name: _____DOB: _____ Age: _____

Address: _____

Parent/Guardian: _____ Phone: _____

Client Status: □ OTC □ DCF Custody □ TPR □ FWSN □ Voluntary □ IEP

Social Worker/Case Manager: _____Phone: _____

Supervisor: _____Phone: _____

Other providers involved: _____

Please list any health issues, at-risk behaviors, mental health diagnosis, educational goals and medications:

_____

Reason for referral: _____

_____

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

I authorize TEEG to conduct a 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 client, a goal-oriented individualized treatment plan will be submitted to the referral agency along with a financial contract for approval.

Authorized Signature: _____

Financial information required

Agency Name: _____

Billing Address: _____

Phone: #1_____ #2 _____ Fax: _____

Email contact information: _____

Client Identification number: _____

Contract Rate for Services: _____ hour ☐ week ☐ month ☐

Start date: _____ Anticipated Completion date: _____

Social Worker/Case Manager: _____

Phone: _____

Supervisor: _____Phone: _____