

The Centers
Adolescent Substance Abuse Residential Services

This residential program is a Level 2 voluntary treatment program that has been established to provide integrated and co-occurring services to adolescents ages 13 through 17 years of age and their families. Appropriate referrals would include adolescents that have developed some dependency or addiction to substances, have a diagnosed or potential mental illness, have been treated unsuccessfully at a lower level of care and/or may be facing incarceration, if they do not volunteer to participate in residential treatment. Once referred, a thorough assessment for appropriateness for the program will be conducted. If not acceptable for residential services, a referral will be made to outpatient services.

Referral

Date: _____

Referring Agency: _____

Agency Contact Person: _____ Contact # _____

Adolescent's Name: _____ SSN: _____ DOB: _____

Parent/Guardian: _____ Contact # _____

(Please ensure that the parent/guardian is aware of the referral and why it is being made)

Address: _____ City: _____ State: _____ Zip: _____

Reason for referral:

Prior Treatment episodes (if known):

Medications (if known): _____

If referral is in lieu of incarceration, please attach some narrative that describes the offense. Please inform the family that they will have to participate in the treatment process, provide proof of income and any insurance information for purposes of determining proper billing. The program does provide a sliding scale payment system for families that qualify.