Justice Works BehavioralCare
Building Better Futures for Youth and Community

Referral Form for Services

Strength-based | Family-centered | Trauma-informed | Outcomes-driven

Please send the referral form to the appropriate office for processing.
Please call us if you have any questions about how to complete this form.
We need all the information completed so that we can proceed as quickly as possible.

☐ **Charleston** Charlestonreferrals@justiceworksbc.org Phone: 843-974-5934 Fax: 843-647-7768	☐ **Florence** Florencereferrals@justiceworksbc.org Phone: 843-407-4167 Fax: 843-407-4378
☐ **Greenville** Greenvillereferrals@justiceworksbc.org Phone: 864-448-3448 Fax: 864-448-3449	☐ **Horry** Horryreferrals@justiceworksbc.org Phone: 843-488-1615 Fax: 843-488-1616
☐ **Richland** Richlandreferrals@justiceworksbc.org Phone: 803-234-6134 Fax: 803-234-6135	**Emma Rava, Clinical Director** erava@justiceworksbc.org

Date of Referral:

Reason for Referral/Statement of Need		
Services Requested	☐ Diagnostic Assessment	☐ Family Support
	☐ Parenting Assessment	☐ Psychosocial Rehabilitative Services
	☐ Therapy Services	☐ Behavioral Modification

****A licensed therapist will make the final recommendations regarding what services would be most effective for you and the family for treatment.**

Referring Person Information

Name		**Email**	Is this a self-referral? ☐Yes ☐ No
Organization Name and Address:			
Phone Number:			

Client Information

Client Name:		Age: _____	DOB: _____
Gender:	☐ Male ☐ Female ☐Other	Primary Language:	
Marital Status:	☐ Single ☐ Married ☐ Divorced/Separated	Race:	
Current Address:			
Client resides:	☐ Home ☐ Foster/Therapeutic Foster Home ☐ Group Home ☐Other		
Email Address:			

Caregiver Contact Information (if client is a child)

Name		Phone Number:	

Email Address:		Relationship to client:	
Name:		Phone Number:	
Email Address:		Relationship to client:	

Involved Agency Contact Information

☐ COC ☐ DJJ ☐ DSS ☐ DMH ☐ DDSN ☐ GAL ☐ Other: _____

Guardian Ad Litem Name: _____ Email: _____

Caseworker Name: _____ Email: _____

Caseworker Supervisor Name: _____ Email: _____

Client Insurance Information

Primary Insurance: ☐ Agency pay ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ Self-pay

Policy #: _____ Social Security #: _____ Policy Holder: _____

Secondary Insurance: _____ Policy #: _____ Policy Holder: _____

**SCAN FRONT AND BACK OF INSURANCE CARD AND SUBMIT WITH REFERRAL

Client Mental Health/Behavioral Health Information

Is client currently receiving behavioral health services? ☐ Yes ☐ No

Name of Provider/Facility: _____

Please list any current or past behavioral health services client has received (i.e., Behavior Modification, Therapy, Family Support Services, Psychosocial Rehabilitative Services, etc.)

Current Medications (name/dosage/prescribed by)

Current Diagnosis (if known)

List any current or prior medical conditions, intellectual, impairments or physical disabilities that a provider needs to accommodate.

CALOCUS Completion ☐ Yes ☐ No ☐ Unsure If yes, Date: _____ Where? _____

Diagnostic Assessment ☐ Yes ☐ No ☐ Unsure If yes, Date: _____ Where? _____

Psychiatric Evaluation ☐ Yes ☐ No ☐ Unsure If yes, Date: _____ Where? _____

****SEND ABOVE DOCUMENTS WITH REFERRAL*** (INCLUDING CALOCUS, CBCL, DIAGNOSTIC ASSESSMENT, PSYCHOLOGICAL, MEDICAL, OR PROGRAM NOTES, DISCHARGE NOTES, ETC.)**