Children's PLACE, INC.

High Risk High Hope™

# Referral Form

☐ Therapeutic Childcare (ages 18 mo. to 5 yrs) ☐ Outpatient Individual/Play Therapy + Family Therapy

Today's Date: _____

Child's Name: _____ Age: _____ Date of Birth: _____

S.C. Medicaid: ☐Yes ☐No

Plan:
☐ Select Health/First Choice
☐ Wellcare
☐ Molina
☐ Absolute Total Care
☐ Bluechoice

Medicaid Number: _____

Parent/Caregiver Name: _____

Contact Number: _____

Address: _____

Reason for Referral/Concerns:
(i.e. behavioral problems, developmental concerns, trauma history, family/environmental stressors)

_____

_____

_____

_____

☐ Self- Referral ☐ Agency-Referral

Agency: _____

Contact: _____

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Aiken, SC 29801

TEL: (803) 641-4144
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childrensplaceinc.org

United Way
United Way of Aiken County, Inc.