All completed information must be submitted via email to the following email recipient:

Referral@RedefiningRefuge.org

Should you have any questions regarding the completion of this Referral Packet, please call:

(813) 733-1311
(813) 997-1953

Program Intake Criteria

Our Specialized Case Management Program is designed for children aged 12-17:

- ✓ who have been identified by DCF and/or Law Enforcement as a Minor Victim of Sex Trafficking and those who are at high risk of commercial sexual exploitation.
- ✓ who are in need of services whether voluntary, as a condition of probation, through a diversion program, or as identified by a community partner.

In order to ensure program effectiveness, the following criteria identify youth who cannot be appropriately served by the Redefining Refuge Specialized Case Management Program. Youth who:

- ✓ Community youth who are currently receiving targeted or intensive CSEC case management services.
- ✓ refuse offered services or if the guardian refuses offered services
- ✓ are actively and acutely psychotic or in need of 24 hour medical/psychiatric treatment.
- ✓ are actively suicidal or homicidal youth for whom the program cannot provide additional measures to assure the youth's (or others) safety.
- ✓ who test positive for narcotics, amphetamines and/or barbiturates during an initial routine pre-intake drug screening. Such referrals will require outpatient clearance from a Substance Abuse professional prior to being considered for services.
- ✓ who require the administration of methadone
- ✓ who are in need of an inpatient substance abuse treatment/rehabilitation program as recommended by assessment
- ✓ who are determined to have an IQ less than 80.
- ✓ who have been identified as sex offenders but who are not engaged in related treatment and/or have not successfully completed treatment within a residential sex offender program.
- ✓ who severely endanger other youth by active assaults and crimes and/or gang involvement.

* Redefining Refuge will be mindful to extend varying degrees of flexibility in applying its admission criteria based on each child's individual history, diagnosis, current level of functioning as well as motivation to participate with the program.

Referral Form

Referring Agency (If Applicable)

Referral Source/Name: _____ Phone Number: _____

Agency: _____ Email: _____

Client Demographic Information

Name: _____ Age: _____ DOB: _____

Address: _____

Gender: _____ Race/Ethnicity: _____

Primary Language: _____ Type of Insurance: _____

Current Presenting Problem:

_____

_____

_____

Current and/or recent risk factors (ex: Baker Act, self-injurious, aggression, arrest, substance use)

_____

_____

_____

Medical and/or Mental Health Diagnosis:

_____

_____

_____

Has the child received case management services at any time in the last two years? If yes, please specify.

_____

_____

_____

Any additional information/comments:

_____

_____

_____

Caregiver Demographic Information – Guardianship documentation must accompany this referral

Guardian Name: _____ Phone Number: _____

Placement Type:

- ☐ Biological
- ☐ Non-Relative
- ☐ Relative
- ☐ Adoptive
- ☐ Foster Home
- ☐ Group Home

Services Requested

Please Note: A Needs Assessment will be conducted upon intake to determine the level and details of services requested.

- ☐ Psychiatric/Mental Health
- ☐ Individual Counseling
- ☐ Family Counseling
- ☐ Alternative Therapies (Art Therapy, Music Therapy, Equine Assisted Psychotherapy, etc.)
- ☐ Substance Abuse Counseling
- ☐ Therapeutic / Supervised Visitation
- ☐ Educational Services
- ☐ Other- Please Describe: _____

_____ _____ _____

Name of Person Completing Referral Signature Date

Client Demographic Sheet

Child's Name	
DOB	
SSN	
Ethnicity	
Parent/Primary Caregiver Name	
Law Enforcement Agency Involved and Contact Information	
GAL (if applicable)	
JPO (if applicable)	
Lawyer (If applicable)	
Health Insurance AND Policy Number	
Primary Care Physician & Date of last Well-Child Exam	
Primary Dentist & Date of Last Cleaning Exam	
Current Therapist(s) and/or Psychiatrist	
Current Grade Level	
Current School	
Special Dietary Needs/Allergies (if applicable)	
Medical Equipment (if applicable)	
List of Medications (if applicable)	
Scheduled Extracurricular Activities (Employment, Tutoring, Sports, Clubs, Volunteering, etc)	
Any other pertinent information:	

Parent/Agency Completing Form: _____ Signature: _____

Authorization Letter/Consent for Medical Treatment, Schooling Related Requests and Transportation

To Whom It May Concern:

This letter is to certify the identified youth listed below has been placed in in the temporary custody of the State of Florida. Our agency has a subcontract with Eckerd Connects, the child welfare lead agency for the Department of Children and Families.

Redefining Refuge, Inc. has a Memorandum of Understanding with Eckerd Connects to provide targeted case management and wraparound services to the identified youth listed below. Redefining Refuge, Inc. and its staff shall be responsible to provide proper identification as requested.

Date: _____

Child Name: _____

DOB: _____

SSN: _____

The following agency is authorized to transport and authorize noninvasive medical procedures for the above-named child:

Date: _____

Name of Agency: Redefining Refuge, Inc.

Address: 401 E. Jackson Street, Suite 3300 Tampa, FL 33602

The above-named agency is contracted to the Department of Children and Families, and is permitted to seek routine medical screenings or treatment for the child as deemed necessary, with the exception of invasive medical procedures/treatments, and consent for the prescription of psychotropic medications. The above-named agency is also granted permission to enroll the above-named child in school or educational services.

I certify that all information provided to the above-named Custodian to assist in the care needs of the above-named child.

_____ _____

(Signature of Parent/Legal Guardian) (Date)

Authorization to Release Medical/Mental Health Information

Patient's Name:	DOB:
Parent/Legal Guardian Name:	SSN:
I, _____ (name of Parent/Legal Guardian) authorize representatives of Redefining Refuge, Inc. to release/discuss healthcare information of the patient named above to: Providers Redefining Refuge, Inc. deem necessary	

Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

	I authorize the release of above-named patient's STD results, HIV/AIDS testing, whether negative or positive, to the provider(s) listed above. I understand that the provider(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent/Legal Guardian Signature:		Date signed:

**** THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED