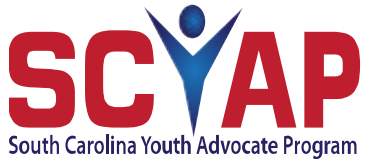
Fax, Mail or E-mail Completed Form to
SCYAP Admissions- Candace Ricketson
E-mail: rbhsreferrals@scyap.com



140 Stoneridge Drive, Suite 350
Columbia, SC 29210
Phone: (803) 779-5500
Fax: (803) 779-8444

South Carolina Youth Advocate Program
Community-Based Services Referral Form

(Please complete to the best of your ability)

***Date of Referral:** _____

Client Information

***Name:** _____ **DOB:** _____ **Gender:** _____ **Race:** _____

***Medicaid #:** _____ ☐Select Health ☐Molina ☐Blue Choice ☐Humana ☐ Absolute Total Care **Legal Guardian:** _____

*Current Client Location/Household and Contact Information:

☐ Family Home ☐ Group Home: _____ ☐ Foster Home ☐ TFC: _____ Level: _____

***Parent/Guardian(s):** _____ **Relationship:** _____

***Address:** _____ ***County:** _____
Street City Zip

***Phone #:** _____ **Email:** _____
Cell Home Work

Referral Source / Caseworker / TFC Contact Information

Referral Source: ☐ **Self** ☐ **State Agency:** _____ ☐**Other:** _____

Contact: _____ **Relationship:** _____ **Office/Location:** _____

***Phone #:** _____ **Email:** _____
Cell Work

Alt. Contact: _____ **Relationship:** _____ **Office/Location:** _____

***Phone #:** _____ **Email:** _____
Cell Work

Current Psychiatric Medications

Medication	Indication/Treatment of:	Dosage	Frequency	Prescriber

Concerns/Reason for Referral:

☐Depression ☐Grief/Loss ☐Anxiety ☐Suicidal Ideation/Attempts ☐ Self-harming Behaviors

☐Trauma ☐Parent/Child Conflict ☐ Aggression ☐Drug/Alcohol Use (Child) ☐Neglect

☐Sexual Abuse ☐Domestic Violence ☐Physical Abuse ☐School Behavior/Attendance ☐ Legal Problems/Delinquency

Services requested and additional explanation of above concerns:

*Required Information