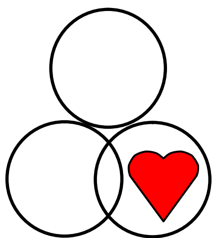

CIRCLES OF CARE INC.

Your Choice for Quality Behavioral Healthcare Services

OUTREACH DEPARTMENT
REFERRAL FOR C.A.T. TEAM

4450 West Eau Gallie Blvd., Suite 200, Melbourne, FL 32934
Office (321) 726-2860 Fax (321) 752-3143

Client Name: ________________________________ Medicaid #:__________________

Parent/Guardian: ____

Address: ____

DOB: ____________S.S.#: ________________Phone # ___________________________

Male / Female (circle one)

Read the following statements, answer yes or no.

Parent/Guardian has been fully informed that treatment from the C.A.T. Team will involve the entire immediate family. YES / NO

Parent/Guardian has committed to fully participate in treatment. YES / NO

Eligibility

Being at risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care. YES / NO

Having two or more psychiatric hospitalizations or repeated failures. YES / NO

Involvement with the Department of Juvenile Justice. YES / NO

Multiple episodes involving law enforcement. YES / NO

Poor academic performance and/or suspensions. YES / NO

** If **Yes** was answered to any of the above eligibility statements, attach supporting documentation of eligibility.*

Submitted by: ____________________________ Agency: __________________________

Contact Phone # _________________________ Date submitted: ____________________

Email Address: ____________________________________