| Rocky Hill  |
| --- |
| CCS Referral |
|  | Place an X in the box to the **left** of the appropriate option.  |
| CCS Consumer Name: |  |
| Age of Consumer |  |
| Area of Need |  | Mental Health |  | Substance Abuse |  | Both |
| Parent/Guardian Name(s): (if child) |  |
| City/Village of Residence and what part (in town, north, south, east, west, etc.): |  |
| School District of Residence |  |
| Grade in school (if applicable) |  |
| School Option (if applicable) |  | School of residence |  | Day Treatment |  | Home Schooled |  | Online |
| Best Form of Contact |  | Phone call |  | Phone text |  | Phone call and/or text |  | email |
| Contact Information |  |
| First Contact Should be |  | Provider contact Consumer |  | Consumer contactProvider |  | ProviderContact Service Provider |
| Summary of Reason for Referral |  |
| What else is important to know: (preferred place to meet, condition of home, pets, cultural, racial, gender identification considerations, language, family dynamics, etc.) |  |
| **Send this form to Michelle Uetz at:** **michelleuetz@rockyhillco.com** **Phone: 715-505-5342** |