Ensuring that child sex trafficking victims receive quality care and services in the State of Georgia

Youth Referral Form

Date:

Referral Source Information

Name of the Person Completing Referral:

Phone Number: Email:

Please check what type of agency/provider you are affiliated with:

☐ Parent ☐ Independent Court ☐ Community ☐ Medical ☐ Mental Health ☐ School

☐ Division of Family and Children Services (DFCS) ☐ Department of Juvenile Justice (DJJ) ☐ Law Enforcement

Is the physical custodian of the youth requesting an assessment within 24 hours of submitting the completed referral?

☐ Yes ☐ No☐ Unknown

Please indicate any scheduling preferences (preferred day or time):

Youth Referral Information

Youth Name: Date of Birth:

Gender: Ethnicity:

Is client currently pregnant? ☐ Yes ☐ No Is client actively parenting? ☐ Yes ☐ No

Language Spoken: Does youth have a disability? ☐ Yes ☐ No

Who has custody of youth? ☐ Parents ☐ Father ☐ Mother ☐ Other Family Relative ☐ DFCS ☐ DJJ/Court ☐ Other:

Dropdown with additional fields if DJJ/Courts is checked:

Status of the case: ☐ Probated ☐ Supervision ☐ Needs Immediate Placement ☐ Commitment

Current and/or past charges:

Placement History:

Court/DJJ Contact Person: Phone/Email:

Dropdown with additional fields if DFCS is checked:

If in custody of DFCS, what is the date custody began?

Status of the case (check boxes): ☐ Investigative ☐ Family Preservation ☐ Needs Immediate Placement ☐ Foster Care

Placement History:

Case Worker Contact Person: Phone/Email:

Youth Address and Location

Listed/Legal Address: County:

Current Location: County:

Is this a safe location? ☐ Yes ☐ No

Legal Guardian

Name of legal guardian: Phone number:

If youth does not reside with legal guardian, provide the phone number for current placement:

Reason for Referral

What is the reason for your referral for sexually exploited/trafficked youth services *(please provide details)*?

Prior History of Exploitation:

Please check all that apply:

☐ Youth Disclosure of Sex Trafficking/Exploitation ☐Runaway History ☐Firearm/Weapon Use

☐ Giving False Name ☐ Gang Involvement ☐ Homeless

☐ Loitering for Solicitation ☐ Substance Abuse ☐ Online Ads for Solicitation

☐ History of Childhood Sexual Abuse ☐Family History in Sexual Exploitation/Trafficking

☐Law Enforcement Involvement in Case

Youth Information

Family/Household Information:
(in home abuse or neglect, family functioning, other siblings, etc.)

Medical History:
(pregnancies, STDs/STIs, chronic health conditions, recent medical exams, etc.)

Mental Health Involvement:
(substance abuse history, mental health diagnosis, current therapeutic provider, etc.)

Juvenile Justice Involvement:

Child Welfare Involvement:

Prior to completing this Referral, did you utilize the Georgia Statewide Screening Tool?

☐ Yes ☐ No

Please attach a copy of the completed screening tool to referrals@gacares.org.

Consent Form and Obtain/ Release of Information

Youth Name: _____

Youth Date of Birth: _____

Section A: Consent to Services

I authorize the complete release of my records. By signing this form, I consent to receive the following services from Georgia Cares: comprehensive assessment; care coordination; and follow-up services after discharge. I understand that by signing this form that I am consenting for the youth identified above to participate in Georgia Cares' treatment services.

Section B: Use and Disclosure of Information

By signing this form, I authorize the disclosure of my individually identifiable information. Information that may be used or disclosed based on this authorization is as follows:

I authorize the release of my complete records including:

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse, mental health disorders, educational issues/needs, legal issues/needs and/or social/recreational issues/needs.
- Information concerning the testing for HIV (Human Immune Virus) and /or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
- Privileged communications between a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning communications with them.
- All education information; including education records created or received by the school system. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluations.

I authorize the disclosure of my complete records and identifiable information **by the following and to the following parties:** Department of Juvenile Justice, Department of Family and Children Services, Educational Provider, Juvenile Court, District Attorney's Office, Law Enforcement, Mental Health Providers, Medical Providers, and any other providers as deemed necessary.

I authorize for Georgia Cares to take a photograph of the abovementioned youth, to be shared **by the following and to the following parties**: Department of Juvenile Justice, Department of Family and Children Services, Educational Provider, Juvenile Court, District Attorney's Office, Law Enforcement, Mental Health Providers, Medical Providers, National Center for Missing and Exploited Children (NCMEC) and any other providers as deemed necessary.

□ I authorize the release of the complete records **except** for the following information or to the following party:
_____.

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is for Assessment Program services, Care Coordination Program services, possible completion of Victim's compensation application, and possible completion of a NCMEC application and other needed uses.

Section D: Expiration

Consent for Release of Information expires **24 months** from the date it was signed. Consent for Information must last no longer than reasonably necessary to serve the purpose for which consent is given (42 CFR 2.31 (a) (9)).

□ By checking this box, I authorize the following expiration event or date that when it occurs, will prohibit Georgia Cares from giving or receiving information as described above (detail expiration date): _____.

Section E: Other Important Information

1. I understand that Georgia Cares cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a youth in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that I may refuse to sign this Authorization and that my refusal to sign may affect my ability to obtain services through Georgia Cares.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by Georgia Cares in reliance on this authorization before written notice of revocation is received.
4. I understand that educational records are confidential under state and federal law and by signing this Unified Release of Information; I am authorizing the release of educational records.
5. I understand that the data collected from the assessment measures may be used for agency program evaluation efforts. All data shared or published is deidentified to maintain client confidentiality.

Signature of Youth: _____ Date: _____

Name of Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____