

TRAUMA INFORMED PARENTING GROUP REFERRAL:

Please note: Referral information needs to include caregiver being referred AND 1 identified youth's information if being billed through Medicaid (*youth must reside in Kent county or caregiver must live in Kent county AND youth needed to be removed from KENT*).

- If removed from and live out of Kent County or hold active non-Kent County Medicaid - private pay is \$50.21 per week (6 weeks total = \$301.26).
- Please note, if in Foster Care, provide a copy of court docs showing out of home placement.
- Commercial Insurance Accepted: ASR, Aetna/Cofinity, BCN/BCBS, Cigna, Magellan, McLaren, Molina, Priority Health. Kent Co. Medicaid Accepted | Cost dependent on individual insurance plan

Please submit this referral form to Melissa Kramer via fax (616) 942-9548 ATTN: Melissa Kramer or email counseling@wedgwood.org at least one week before class start date.

2026 DATE OF GROUP REQUESTING:

- February 25 - April 1 | 5:30 - 7:30pm
- April 15 - May 20 | 5:30 - 7:30pm
- June 10 - July 16 | 5:30 - 7:30pm

- August 5 - September 9 | 5:30 - 7:30pm
- September 23 - October 28 | 5:30 - 7:30pm
- *November 10 - December 15 | 5:30 - 7:30pm
*TUESDAYS

CAREGIVER ATTENDING INFORMATION:

CAREGIVER LAST NAME: _____

CAREGIVER FIRST NAME: _____

CAREGIVER MAILING ADDRESS: _____

CAREGIVER EMAIL ADDRESS: _____

CAREGIVER PHONE NUMBER: _____

YOUTH INFORMATION:

YOUTH LAST NAME: _____

YOUTH FIRST NAME: _____

YOUTH MIDDLE NAME: _____

AKA/OTHER IDENTIFYING INFO: _____

YOUTH GENDER (ASSIGNED AT BIRTH): _____

YOUTH SOCIAL SECURITY NUMBER: _____

YOUTH DATE OF BIRTH: _____

YOUTH ADDRESS: _____

CITY/STATE/ZIP CODE: _____

YOUTH PRIMARY PHONE NUMBER: _____

YOUTH MEDICAID ID NUMBER: _____

COMMERCIAL INSURANCE POLICY #: _____

FOSTER CARE? _____

OKAY TO MAIL TO?

OKAY TO LEAVE A MESSAGE?

INSURANCE INFO: _____

POLICY HOLDER NAME & DOB: _____

REFERRAL CONTACT: _____