

YOUTH COORDINATOR REFERRAL FORM

PLEASE SUBMIT TO:
TAMMY CHERRY/ PROGRAM MANAGER
 11716 ENTERPRISE DRIVE AUBURN, CA 95603
 (530)886-2867 OFFICE/ (530) 886-2810 FAX
 TCHERRY@PLACER.CA.GOV

WAS THIS REFERRAL FILLED OUT WITH/ BY THE PERSON BEING REFERRED? YES NO

NAME OF PERSON BEING REFERRED:	ETHNICITY:
DOB:	COUNTY OF ORIGIN:
TELEPHONE(PERSON BEING REFERRED/ PLACEMENT)/ TYPE:	NECESSITY: <input type="checkbox"/> AS AVAILABLE <input type="checkbox"/> IMMEDIATE
PLACEMENT ADDRESS (IF APPLICABLE) :	
CITY/ STATE:	ZIP CODE:
PARENT(S)/CAREGIVERS(S) - RELATIONSHIP (IF APPLICABLE):	CAREGIVER'S TELEPHONE/ TYPE:
HOME ADDRESS: (IF NONE, IS THIS PERSON HOMELESS? YES <input type="checkbox"/> NO <input type="checkbox"/>)	
CITY/ STATE:	ZIP CODE:
LEVEL OF ANTICIPATED INVOLVEMENT:	
<input type="checkbox"/> ONE TIME CONTACT <input type="checkbox"/> OCCASIONAL/ PERIODIC <input type="checkbox"/> MORE INTENSIVE INVOLVEMENT	
IEP: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	26.5: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
CURRENT SYSTEM/ SERVICES RECEIVED: (PLEASE CHECK ALL THAT APPLY):	
PROBATION: YES <input type="checkbox"/> PREVIOUSLY <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	
CHILD WELFARE SERVICES: YES <input type="checkbox"/> PREVIOUSLY <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	
MENTAL HEALTH SERVICES: YES <input type="checkbox"/> PREVIOUSLY <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	
WRAPAROUND: YES <input type="checkbox"/> PREVIOUSLY <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	
OTHER SERVICES / SUPPORTS NOT ALREADY MENTIONED (PLEASE LIST):	

OTHERS INVOLVED (I.E. CASA WORKER, FAMILY MEMBERS, ETC.):

NAME: _____ RELATIONSHIP: _____
CONTACT INFORMATION: _____
NAME: _____ RELATIONSHIP: _____
CONTACT INFORMATION: _____
NAME: _____ RELATIONSHIP: _____
CONTACT INFORMATION: _____

TYPE OF PLACEMENT (CHECK IF APPLICABLE):

- | | | |
|---|--|--|
| <input type="checkbox"/> EMERGENCY SHELTER | <input type="checkbox"/> GROUP HOME/ LEVEL: | <input type="checkbox"/> BOOT CAMP |
| <input type="checkbox"/> NON-RELATED EXTENDED FAMILY MEMBER (NREFM) | <input type="checkbox"/> MENTAL HEALTH FACILITY | <input type="checkbox"/> RESPITE FOSTER HOME |
| <input type="checkbox"/> FOSTER HOME | <input type="checkbox"/> JUVENILE DETENTION FACILITY | <input type="checkbox"/> TYPE UNKNOWN |

NAME OF SCHOOL/ VOCATIONAL TRAINING PROGRAM (IF APPLICABLE):

ADDRESS:

CITY/ STATE:

ZIP CODE:

OTHER SCHOOL SERVICES, CLUBS, AND/OR RESOURCES:

PLEASE LIST ANY ONE TIME AND/OR ONGOING MEETINGS AND OTHER IMPORTANT DATES (I.E. COURT, TDM, FTM, PRT, SMT, GRADUATION, EMANCIPATION, MOVING DATE):

REASON FOR REFERRAL:

REFERRING PERSON/ AGENCY:

PHONE NUMBER:

DATE:

Responsible Party/ Guardian Signature:

Date _____

By signing this document you are giving consent for (Youth's Name) _____ to receive services through the Placer County Youth Empowerment Support (YES!) Program