Arkansas Department of Human Services
Division of Children and Family Services
Referral for Transitional Services & Support

(To be completed by the FSW)

TO: _____ (TYS Coordinator) Area: _____ Date: _____

FROM: _____ (FSW) Phone: (_____) _____ _____ County: _____

Youth's Name: _____ Birth Date: _____ Age: _____ Gender: _____

Case Name: _____ Case #: _____ Client ID: _____

Email: _____ Phone: (_____) _____ _____

Address: _____

City: _____ State: _____ Zip Code: _____

Foster Parent / Facility Name: _____

TO BECOMPLETED BY FAMILY SERVICE WORKER: (Check all boxes and provide all the information that applies.)

1. Youth has been informed about Transitional Services? ……..... ☐ YES ☐ NO
2. Youth has a Transitional Team? …….. ☐ YES ☐ NO
3. Youth is at least 14 years old, and is neither currently incarcerated, nor on a trial home visit? ☐ YES ☐ NO
4. Youth wants to participate? …… ☐ YES ☐ NO
5. Youth was given a copy of PUB-50: Be Your Own Advocate? ……..... ☐ YES ☐ NO
6. The Life Skills Assessment has been completed? ……..... ☐ YES ☐ NO

   If Yes, date assessment was completed: _____ Overall Assessment Score: _____ %

COMMENTS:

YOUTH IS BEING REFERRED FOR (Select only those that apply.):

- ☐ Life Skills Classes
- ☐ Assessment & Reassessment
- ☐ Benefits (household start-up, post-secondary tuition, etc.)
- ☐ Transitional Team Participation
- ☐ Support for Youth's Transitional Goal of Employment or Education

_____ _____ _____
Family Service Worker Name Family Service Worker Signature Date

_____ _____
Youth's Signature **(REQUIRED)** Date

_____ _____
Coordinator's Signature Date

TO BE COMPLETED BY THE TYS SUPERVISOR:

Youth is approved for the following:

- ☐ Life Skills Classes
- ☐ Assessment & Reassessment
- ☐ Benefits (household start-up, post-secondary tuition, etc.)
- ☐ Transitional Team Participation
- ☐ Support for Youth's Transitional Goal of Employment or Education

_____ _____ _____
TYS Supervisor Name TYS Supervisor Signature Date