



Division of Youth Services

Intensive In-Home Services Referral Form



Youth Name:		Youth DOB:	
PASSE (if applicable):		Care Coordinator:	
Coordinator Email:		PASSE Tier:	

Check all that apply:	<u>Risk Factors</u> Defiant/oppositional Delinquent Family conflict FINS history Fire-setting Gang association Homicidal ideation Physical aggression Problem sexual behavior Property destruction Self-harm Substance use Suicidal ideation Trauma history Truancy Verbal aggression	<u>Protective Factors</u> Acknowledges risk-factors Completed problem sexual behavior treatment Completed substance use treatment Positive adult influences Pro-social activities Positive peers Positive school performance Resilient personality Strong family connection Supportive caregiver(s) Utilizes community resources (case management, counseling, etc.)
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Is the youth 17 or younger?	YES	NO
Are services court ordered?	YES	NO
Is the family actively seeking help?	YES	NO
Is the family willing to commit to program requirements?	YES	NO
Are there safety concerns that would prevent staff entering the home?	YES	NO
Have alternative community supports been attempted?	YES	NO
SAVRY Score (if SAVRY has been completed):	LOW	MODERATE
		HIGH



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REFERRING TO (for DYS completion only): ST. FRANCIS YOUTH ADVOCATE PROGRAMS CONNECTED FAMILIES
CENTERS FOR YOUTH & FAMILIES GUIDANCE CENTER IMPACT COUNSELING SPARC YV

Youth Name:		Youth DOB:	
Gender:		Race:	
Social Security:		Medicaid ID	
Address:			
County of residence:		Current FINS:	YES NO
Education Track:	High School	Credits:	of 22
	GED	Status:	
	Current Educational Institution:		
Guardian Name:		Preferred Language:	
Guardian Phone:			
JPO (if applicable):		DHS Worker (if applicable):	
JPO Phone:		DHS Worker Phone:	
JPO Email:		DHS Email:	
Case manager (if applicable):		Therapist (if applicable):	
Case manager phone:		Therapist phone:	
Case manager email:		Therapist email:	
Reasons for referral:			
Criminal History	Charges/Charge Date/Court: (Please include the charges, charge date, and juvenile court.)		
	Pending Charges/County: (Please include the charges, charge date, and juvenile court.)		
	Is youth currently on probation? YES NO		
Health and Medical	Diagnoses:		

	Treatment History (acute placements, residential settings, etc.):		
	Medications:		
	Additional Medical Information:		
Family Involvement	Does the family participate in treatment?		
	<div>YESNO</div>		
	Who lives in the home?		
	NAME	DOB	RELATIONSHIP
Comments:			

History of Abuse & Trauma	Substance	Physical	Sexual
	Comments:		
Additional Information:			

Submitting Party:		Date Completed:	
Organization:			

Submitting Party Signature

Date