

CONFIDENTIAL



REACH ASHLAND YOUTH CENTER

COST REFERRAL FORM

If you suspect Child Abuse or Neglect, YOU MUST notify Child Protective Services at 510-259-1800.

Name: _____ Is youth/ member aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Today's date: _____	Date of Birth: _____	Age: _____	Gender: M _____ T _____ F _____ Q _____
Caregiver name/ relationship: _____ Is caregiver aware of COST referral?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Caregiver contact number: _____	REACH Member?: <input type="checkbox"/> Yes <input type="checkbox"/> No Siblings at REACH? [Names]: _____		
Address: _____	City: _____	State/ Zip code _____		
Name/title/contact info of person making referral: _____	Primary Language: _____ Is a translator needed: <input type="checkbox"/> Yes <input type="checkbox"/> No			

STRENGTHS

<input type="checkbox"/> Problem solver <input type="checkbox"/> Articulates feelings <input type="checkbox"/> Asks for help <input type="checkbox"/> Cooperates/compromises <input type="checkbox"/> Regular attendance <input type="checkbox"/> Demonstrates ability to focus <input type="checkbox"/> Sense of humor <input type="checkbox"/> Able to maintain a job, or commitment	<input type="checkbox"/> Enjoys and is engaged at school <input type="checkbox"/> Self confident <input type="checkbox"/> Follows instructions <input type="checkbox"/> Listens well <input type="checkbox"/> Helpful to others <input type="checkbox"/> Able to admit his/her wrongs <input type="checkbox"/> Builds friendships/is good friend <input type="checkbox"/> Leadership skills	<input type="checkbox"/> Engages in resilience factors (e.g. creativity, imagination, meaningful relationships, etc.) <input type="checkbox"/> Focused on the future/planning <input type="checkbox"/> Respectful to adults <input type="checkbox"/> Supportive family	OTHER STRENGTHS: _____
---	--	---	----------------------------------

CONCERNS & OBSTACLES

<u>Academics/Vocational</u>	<u>Emotional/Mental Health</u>	<u>Social</u>	<u>Health/Basic</u>
<input type="checkbox"/> Ongoing Concern <input type="checkbox"/> Recent Changes (Approx. date of change _____) <input type="checkbox"/> Existing IEP <input type="checkbox"/> Existing 504 Plan <input type="checkbox"/> Other Accommodations: _____ <input type="checkbox"/> Learning Difficulties (Subject/s _____) <input type="checkbox"/> Insufficient Credits <input type="checkbox"/> Suspensions/Expulsions <input type="checkbox"/> Behavioral Dysregulation/Trouble Focusing/Paying Attention <input type="checkbox"/> Conflicts with Authority <input type="checkbox"/> Chronic Lateness/Absences <input type="checkbox"/> Lack of Access to System Supports (e.g. IEP, 504, work permits) <input type="checkbox"/> Other (Please explain): _____	<input type="checkbox"/> Ongoing Concern <input type="checkbox"/> Recent Changes (Approx. date of change _____) <input type="checkbox"/> Self Esteem/ Self Worth <input type="checkbox"/> Identity <input type="checkbox"/> Chronic Sadness/Depression <input type="checkbox"/> Isolating/Withdrawn Behavior <input type="checkbox"/> Anger/Externalized Emotional Expression <input type="checkbox"/> Trauma Exposure <input type="checkbox"/> Suicidal Ideation/Attempts <input type="checkbox"/> Self-Injury/Cutting <input type="checkbox"/> Grief-Related Issues <input type="checkbox"/> Witness/Victim of Violence <input type="checkbox"/> Intimate Partner/Teen Dating Violence <input type="checkbox"/> Perpetrator of Violence <input type="checkbox"/> Anxiety/Fear <input type="checkbox"/> Difficulty Adjusting to Life Transitions <input type="checkbox"/> Other (please explain): _____	<input type="checkbox"/> Ongoing Concern <input type="checkbox"/> Recent Changes (Approx. date of change _____) <input type="checkbox"/> Family/ Child Relational Conflict <input type="checkbox"/> Community Conflict <input type="checkbox"/> Gang Related/Affiliated/Active Involvement <input type="checkbox"/> Foster Care Involvement <input type="checkbox"/> Juvenile Justice Involvement <input type="checkbox"/> Bullying Behavior <input type="checkbox"/> Being Bullied <input type="checkbox"/> Newcomer/UIY/ Immigration <input type="checkbox"/> Survivor of Abuse (Child, Sexual, Physical, Emotional) <input type="checkbox"/> At Risk for Sexual Exploitation &/or Perpetration <input type="checkbox"/> Target/Victim of Hate Crime <input type="checkbox"/> Other (please explain): _____	<input type="checkbox"/> Ongoing Concern <input type="checkbox"/> Recent Changes (Approx. date of change _____) <input type="checkbox"/> Pregnant/Parenting <input type="checkbox"/> Eating Concerns (circle all that apply: restricting food, not eating, overeating/bingeing, purging) <input type="checkbox"/> Basic Needs (circle all that apply: food, shelter, clothing, transportation) <input type="checkbox"/> Health Issues (circle all that apply: vision, dental, stomach, headaches) <input type="checkbox"/> Immediate Threat to Safety <input type="checkbox"/> Substance use (specify: _____) Sexual Health (specify: _____) <input type="checkbox"/> Chronic Health Condition(s) <input type="checkbox"/> Other (please explain)

Email referral form to: Wellness.Referral@acgov.org

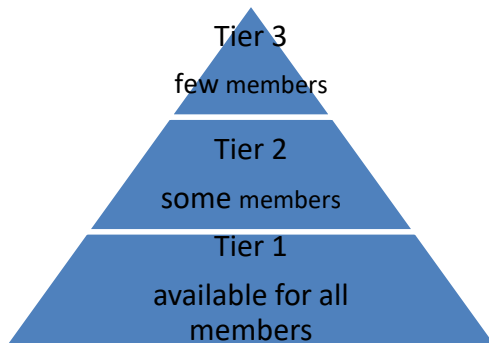
PRIOR INTERVENTIONS AND RECOMMENDATIONS
Indicate at least 3 Interventions before making referrals

Interventions (what have you tried?) <input type="checkbox"/> Talked with member one-on-one <input type="checkbox"/> Consultation/Support from staff <input type="checkbox"/> Case Management within program <input type="checkbox"/> Verbal/written agreements <input type="checkbox"/> Capacity building skills training/coaching <input type="checkbox"/> Spoke with and/or met caregiver <input type="checkbox"/> Spoke with and/or met with other relevant adult supports (e.g. teachers, Probation Officers, primary care providers, etc.) <input type="checkbox"/> Other:	<u>RECOMMENDATIONS:</u> 1. _____ 2. _____ 3. _____	How would you rate this student's level of need? (<i>please refer to 3 Tier DIAGRAM below for explanation of tiers</i>) <input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <i>NOTATION:</i> _____ _____
---	--	--

Tier 3:
Intensive Interventions (Ind. Therapy, Crisis Intervention, etc.)

Tier 2:
Early Interventions (Drop-in case management, Caregiver Engagement, Positive Youth Development, etc.)

Tier 1:
Prevention and Promotion (Agency-wide activities, Member Orientation, Assembly Circles, etc.)



If not opened for services/supports, what supports were given to member and/or family?

Other information:

COST COORDINATOR TO COMPLETE:

Medical Insurance? Yes No UKN Type of Insurance: _____

RECOMMENDED DISPOSITION OF SERVICES: *See below*

Area of Support	REACH Contact	Date of referral	External Contact	Date of Contact
Recreation				
Education				
Arts				
Career/ Vocational				
Health- Mental Health Counseling				
Health- Primary Care				
Library				
The NEST/Childcare				
Basic Needs Support: Housing, food, clothing				
Legal Support: immigration, probation, child welfare				
Other:				