



Please return
completed referrals to:
compass@spectrumvt.org
fax: (833) 857-8969

*Referrals can be faxed or
emailed. If sending by email,
please note that email
is not a secure form
of communication.*

Prevention and Stabilization Support for Youth (ages 12-22) and their Families

Client Contact Information

Name: _____ Date: _____ Gender: _____ Gender at birth: _____

Social Security #: _____ Birth Date: _____ Age: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Ways to contact them: Phone Voicemail E-mail Drop-in

Phone #: _____ E-mail: _____ Other: _____

Best time / day to be reached: _____ OK to leave a message? Yes No

Current living situation (where did they sleep last night?) _____

Do they have health insurance? Yes No

If yes: Medicaid Other: _____

Do they have pets in the home? Yes No

If yes, what kind? _____

Do they have firearms in the home? Yes No

If yes, are they locked? Yes No

Reasons for the referral (check all that apply)

- 12 - 23 homeless justice involved
- runaway pregnant or parent at-risk

Needs for accessibility:

- Interpreter (language) _____
- Accessible room _____
- Other needs (please specify) _____

Have they ever been involved with the Department of Children and Families (DCF)? Yes No

If yes, please explain their status and circumstances (custody, probation, name of worker, etc):

Have they ever been diagnosed with anything (ADHD, depression, anxiety, etc)? Yes No

If yes, please list them: _____

Do they, or anyone in their home, have a history of violence towards themselves or others? Yes No

If yes, please explain: _____

Have they had any involvement with law enforcement/police, probation, or court diversion? Yes No

If yes, please detail all charges and dates, including open and pending charges (to the best of your ability):

Please check other support services they are working with. If checked, may we contact them (please circle y or n)? If yes, please provide contact if you have it.

- Riverstone Counseling: y | n Contact: _____
- Other Counseling: y | n Contact: _____
- Spectrum JOBS Program: y | n Contact: _____
- Spectrum Youth Development Program: y | n Contact: _____
- Spectrum Multicultural Youth Program: y | n Contact: _____
- Spectrum Housing: y | n Contact: _____
- COTS: y | n Contact: _____
- Emergency Housing/State of VT: y | n Contact: _____
- VT DCF: y | n Contact: _____
- Steps to End Domestic Violence: y | n Contact: _____
- Probation/Parole/Diversion: y | n Contact: _____
- DOL/Voc Rehab: y | n Contact: _____
- School / Education: y | n Contact: _____
- Howard Center: y | n Contact: _____
- Other: y | n Contact: _____

Referrer Contact Information

Person or agency filling out this referral: _____

Can we contact you? Yes No

If yes, please provide your contact information: _____

Describe your or your agency's current involvement: _____
