Please return
completed referrals to:

referrals@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: ____________________

____