Youth Development Program
REFERRAL

Youth Name:	Date of Referral:
D.O.B.:	DCF Family #:
S.S.N.:	Medicaid UID:
Address:	
Phone/Contact #:	Email address:

Referral Source:	Phone/email:
DCF Case Worker:	DCF District:
Date of DCF Custody:	DCF Discharge Date:

Reason for Referral:

☐ Life Skills Assessment ☐ Extended Care ☐ Family Support
☐ Identification and Development of Permanent Connections ☐ Applying to College/Financial Aid
☐ Individual Life Skills Instruction ☐ Case management ☐ Community referrals
☐ Life Skills Groups
☐ Other _____

Housing:

Youth's current living situation:
Short-term and long-term housing related goals:

Education:

Currently enrolled?	□ Yes □ No
School name and address:	
GED/HS Diploma:	□ Yes □ No
IEP/504 Plan:	
Education surrogate:	
Guidance counselor/advisor:	
VSAC:	
Short-term and long-term education related goals:	

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Employment:

Currently employed?	□ Yes □ No
Where?	
Supervisor:	
Since:	
Hours per week:	
Short-term and long-term employment related goals:	

Medical Information:

Health Insurance:	
Special health needs:	
Mental health diagnosis:	
Current medication:	
Prescribing doctor:	
Phone:	
Counselor/therapist:	
Dental care:	
Pregnant or parenting:	

Legal:

Past or present involvement with law enforcement, probation, or court diversion:	
Probation Officer and Phone #:	

Transportation:

Driver's license/permit:	□ Yes □ No
Vehicle:	□ Yes □ No
Driver's education:	

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Future plans/interests/skills/strengths:

Any known **challenges, difficulties, triggers, trauma, significant information, or barriers** to youth participation in the program:

Please describe your **expectations for Youth Development Program involvement** and activities.

Please submit completed referral form with this youth's most recent case plan to referrals@spectrumvt.org.