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: __________

Client's#: ____________________ Guardian's phone #: ____________________ Email: __________

Okay to leave voicemail? ☐ Yes ☐ No   Best time/day to be reached ____________________

I have informed the following of the referral: Client Caregiver Neither

Contact occurred via: In person Phone call Text message Email No contact made

Reason for accessing services: ____

____

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: ____

____

Please note incomplete referrals will not be accepted