OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM

REFERRAL FORM

Reason	Area	Staff

PLEASE PRINT in BLACK INK

Last *First* *Middle*

Sex *Date of Birth*

Address *City* *Zip Code*

Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Multi-racial ☐

Mother's Name	*Address*	*City and Zip*	*Email*	(W) (H) (Cell) *Phone*
Father's Name	*Address*	*City and Zip*	*Email*	(W) (H) (Cell) *Phone*
Step-Parent or Guardian (living with child)	*Address*	*City and Zip*	*Email*	*Phone*

Name of School *Grade* *School District* *Name of Local Youth Assistance Program*

BRIEF DESCRIPTION OF REASON FOR REFERRAL *(use additional sheets if necessary)*

★ **Upon acceptance of services, families will be assessed a $25 processing fee** ★

Have other agencies or school services been involved? Yes ☐ No ☐

If yes, who?

Is parent aware of referral? Yes ☐ No ☐ Is youth aware of referral? Yes ☐ No ☐

Has parent been informed of processing fee? Yes ☐ No ☐

Signature of Referring Person: _____ **Date:** _____

(signature required for processing)

Print Full Name and Job Title of Referring Person: _____

Address: _____ *City and Zip Code:* _____

Telephone: _____ *Agency:* _____

July 2017