|  |  |  |  |
| --- | --- | --- | --- |
| **REFERRAL SOURCE** | | **FUNDING SOURCE** | |
| Referral Date: |  | Court-Ordered Psychologicals (VA Code §16.1-275) | |
| Worker’s Name: |  | Mental Health Initiative | Substance Abuse |
| CSU or CAP: |  | Residential (Probation) | Indep. Living (Parole) |
| Phone: |  | Direct Care | Detention Re-Entry |
| E-mail: |  | Transitional Serv.(“294”) | Salary Match Grant |

**JUVENILE’S NAME:**   **JUVENILE NUMBER:**  .

**BACKGROUND**

**DOB:**   **AGE:**   **GENDER:** \_\_\_\_\_\_\_

**OVERALL RISK LEVEL:** \_\_\_\_\_\_\_\_. **DYNAMIC RISK LEVEL:** \_\_\_\_\_\_

**CURRENT SUPERVISION STATUS:** \_\_\_\_\_\_. **CURRENT LIVING SITUATION:** \_\_\_\_\_\_\_\_\_

**OTHER FUNDING SOURCES AVAILABLE:** Medicaid FAPT/CSA Private Insurance Other:\_

**SESERVICE REQUEST**

**Explain alternative funding sources that have been explored and/or ruled out:** .

**CRIMINOGENIC NEED SERVICE DOSAGE PROVIDER (DSP)**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_\_\_ |  |  | . |
| \_\_\_\_\_\_\_ |  |  |  |
| \_\_\_\_\_\_\_ |  |  |  |
| \_\_\_\_\_\_\_ |  |  |  |

**AREAS OF RESPONSIVITY:**  Include info about relevant trauma, gender identity needs, and other potential barriers i.e. motivation, transportation or language...

**SERVICE REQUEST**

**SEXUAL OFFENDER REGISTRY?** Choose an item. \_\_\_\_\_\_\_\_

**REQUESTED START DATE:**   **OTHER:**  .

**CUSTODIAN**  . **ANTICIPATED SUPERVISION STATUS:** \_\_\_\_\_\_.

**SERVICE LOCATION:** Choose an item. Explain

OTHER CURRENT SERVICES**:**  list here

**RATIONALE FOR *ALL* INITIAL REQUESTS AND EXTENSIONS**

1. *Summarize how the requested service or intervention addresses the identified criminogenic needs and priorities as identified by the YASI Risk Assessment and Behavioral Analysis. Provide a rationale for use of specific a DSP, service type, and dosage (including frequency and length of services request).*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ***For an Extension*** *please provide a brief summary of the progress made during treatment, the reason an extension is being requested, anticipated discharge, the specific targets to be addressed and outcomes to be met if services continue.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FOR COURT-ORDERED PSYCHOLOGICALS ONLY*** *VA Code §16.1-275*

**NEXT COURT DATE:** enter date **OFFENSE TYPE:** select an option

**INDIGENT?**  Yes  No **COMMITMENT ELIGIBLE?**  Yes  No **DETAINED?**  Yes  No If yes, name

Goal of the evaluation or questions to be answered: .

***INFORMATION FOR PAROLE AND DIRECT CARE CASES ONLY***

**DIRECT CARE PLACEMENT (JCC/CPP):**

**COMMITMENT DATE:**  select here **ANTICIPATED PAROLE DATE**:

**COMMITTING OFFENSES:** list here **MENTAL HEALTH ELIGIBLE?** Choose an item.

**RECOMMENDED FOLLOW UP TREATMENT** **by CCRC or Treatment team of JCC/ CPP *(attach plan)***

Aggression Management:  Youth with Sexualized Behavior: \_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

***REQUESTS FOR INDEPENDENT LIVING AND RESIDENTIAL PROGRAMS ONLY***

*Summarize the home environment, explain why the juvenile cannot return home and summarize other placement options pursued/exhausted (e.g. parents, relatives, other adults, DSS, DRS). Indicate: Where will the juvenile live at the completion of the placement? What is the back-up plan if funding or bed space is not available? What community-based services, if any, will be needed as a supplement to services provided by the residential placement? What is the juvenile’s educational status and how will his/ her educational needs be met during the residential placement?.*

**DOCUMENTS ATTACHED *(attach all appropriate information for new referrals)***

**BADGE Face Sheet**

CAP Assessment(s)

Case Plan Court Order

JCC/BSU Reports

MHSTP  **Rationale**

**Release Form**

Social History YASI Wheel

YASI Behavioral Analysis

Other list here

*Please check to insure the referral is complete and all necessary items are attached.*

Confirm HERE. , I , Staff completing request verify that this referral packet is complete, all required documents are included, and the **Supervisor Review** occurred on select date here with **Supervisor.**