|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **REFERRAL SOURCE** | | | | | | | | | | |
| Region |  | | CSU # | |  | FIPS # | |  | | | Referral Date: |  |
| PO Name: | |  | |  | | | | | | | | |
| E-Mail | |  | | | | | Phone: | |  | | | |
| CAP Staff: | |  | |  | | | | | | | | |
| E-Mail | |  | | | | | Phone: | | |  | | |

**JUVENILE’S NAME:**  \_\_ \_ \_\_\_ **JUVENILE NUMBER:** \_\_ \_\_\_\_\_

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

**SEXUAL OFFENDER REGISTRY**:

**BACKGROUND**

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

**CURRENT LIVING SITUATION:**  : \_\_  **CUSTODIAN**

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

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

**OTHER CURRENT/ RECENT SERVICES:**

**OTHER FUNDING SOURCES:**  Medicaid  CSA  Private Insurance  Other:

**DSS INVOLVED/ FOSTER CARE?**  YES  NO

**Explain alternative funding sources utilized, explored, and/or ruled out:**

**OTHER CURRENT/ RECENT SERVICES:**

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

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

**POTENTIAL BARRIERS INCLUDE:** (check all that apply):  Language  Transportation  Trauma

**SERVICE REQUEST**

**AREAS OF RESPONSIVITY:**

**REFERRAL TYPE:**   **REQUESTED START DATE:**  or OTHER: .

**SERVICE LOCATION:**

**RATIONALE FOR *ALL* REQUESTS**

**RATIONALE**: 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).   
FOR EXTENSIONS - Provide a summary of the progress, the reason an extension is being requested, anticipated discharge date, the specific targets to be addressed, and outcomes to be met if services continue

**FOR PSYCHOLOGICALS AND EVALUATIONS**

**DATE OF COURT ORDER:**   **NEXT COURT DATE:**

**OFFENSE TYPE:**  \_\_\_\_\_\_\_\_\_\_\_\_  **COMMITMENT ELIGIBLE?**   Yes  No

**INDIGENT?**  Yes No **DETAINED?**   Yes  No If yes, where

**GOAL OF THE EVALUATION/ QUESTIONS TO BE ANSWERED:**

**FOR PAROLE AND DIRECT CARE CASES ONLY**

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

**COMMITMENT DATE:**  **ANTICIPATED PAROLE DATE:** \_\_\_\_\_\_\_\_

**COMMITTING OFFENSES:**  **MENTAL HEALTH ELIGIBLE?**

**RECOMMENDATIONS FROM CCRC, JCC, OR CPP:** \_\_\_\_

**FOR INDEPENDENT LIVING AND/OR 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 the juvenile live at the completion of the placement; the back-up plan if funding or bed space is not available; community-based services, if any, will be needed as a supplement to services provided by the residential placement; the juvenile’s educational status; and how will his/ her educational needs be met during the residential placement.

**EDUCATION STATUS:** \_\_\_\_

**DOCUMENTS ATTACHED**  Attach all appropriate information for new referrals.

**BADGE Face Sheet**

CAP Assessment(s)

Case Plan Court Order

JCC/BSU Reports

MHSTP  **Release Form**

YASI Behavioral Analysis

Social History YASI Wheel

Other list here

**Confirm HERE.** I, verify that this referral packet is complete, all required documents are included. The **Supervisor Review** occurred on with **.**

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