ALEXANDER YOUTH NETWORK

Once you've completed the referral form, please email it to intake@aynkids.org or you can fax it to (704)362-6751

Attn: Intake Dept. If you have any questions, you can reach the Intake Department by calling (855) 362-8470.

REFERRAL FORM

Name of person completing form: _____

Agency: _____

Contact Information: (Phone/Email): _____

Date: _____

Service(s) Requested, select from options below, indicate Primary as 1, Secondary as 2, if additional, indicate by number.

____ Comprehensive Clinical Assessment
____ Outpatient Therapy – Substance Abuse
____ Multi-Systemic Therapy
____ Substance Abuse Intensive Outpatient
____ Intensive Alternative Family Treatment
____ PRTF
____ Outpatient Therapy
____ Intensive In-Home
____ Day Treatment
____ Therapeutic Foster Care
____ Adolescent Substance Abuse Program (ASAP)

Date of most recent assessment (CCA), if applicable: _____

If additional space is needed for any question, add an extra sheet or write on the back of the application; be sure to give question number for reference.

I. Family Information

Child:

1. Child's Name: _____ 2. Nickname: _____
Last First Middle

3. Address: _____
Number Street/Unit City, State Zip Code

4. Date of Birth: _____ Verified? Yes ___ No ___ 5. Gender: Female: ___ Male: ___
Month Day Year

6. Race: _____ 7. Social Security No: _____-_____-_____

8. Place of Birth: _____
City State Country

9. Currently Living With: Biological Parents: ___ Relative: ___ Foster Family: ___ Other: _____
(Specify)

Biological Parents:

Mother

10. Name: _____ 11. DOB: _____
Last First Middle Month Date Year

12. Address: _____ 13. Email: _____
Number Street/Unit City, State Zip Code

14. Phone Number: _____ 15. Race: _____

16. Religion: _____ 17. Marital Status: single ___ married ___ separated ___ divorced ___

Father

18. Name: _____ 19. DOB: _____
Last First Middle

20. Address: _____ 21. Email: _____
Number Street/Unit City, State Zip Code

22. Phone Number: _____ 23. Race: _____

24. Religion: _____ 25. Marital Status: single ___ married ___ separated ___ divorced ___

Current Parental Relationships: (The persons, if other than biological parents, who will be working in a parental capacity with child while in care):

Caregiver

26. Name: _____ 27. DOB: _____
Last First Middle

28. Address: _____ 29. Email: _____
Number Street?Unit City, State Zip Code

30. Phone Number: _____ 31: Relationship to Child: _____
Specify

Caregiver

32. Name: _____ 33. DOB: _____
Last First Middle

34. Address: _____ 35. Email: _____
Number Street?Unit City, State Zip Code

36. Phone Number: _____ 37: Relationship to Child: _____
Specify

38. Have proceedings been initiated to terminate parental rights for this Child's: Mother _____ Father: _____

If yes, give the date of the final order terminating parental rights of the Mother: _____ Father _____

39. Has Child been adopted: Yes ____ No ____. If yes, give dates of the final adoption orders: _____

II. Custody

Legal Custodian:

40. Name: _____ 41. Phone Number: _____
Last First Middle

42. Address: _____ 43. Email: _____
Number Street/Unit City, State Zip Code

Contact Person:

44. Name: _____ 45. Email: _____
Last First Middle

46. Phone Number: _____ 47. Alternate Number: _____

48. Is a "Voluntary Placement Agreement" in effect: (Circle one) Yes No If yes, expiration date:_____

III. Presenting Problem

Please tell what is going on in the family at this time. Describe the significant events which affect this family and child:

If additional space is needed for any question, add a note below and be sure to give question number for reference.

The following pages are to be completed for Foster Care referrals ONLY.

IV. Family Relationships

CHILD'S SIBLINGS (Include child's biological, half, step, and adoptive siblings):

49. **Name**: _____ Phone Number: _____

Address: _____ Relationship: _____
Number Street/Unit City, State Zip Code

50. **Name**: _____ Phone Number: _____

Address: _____ Relationship: _____
Number Street/Unit City, State Zip Code

51. **Name**: _____ Phone Number: _____

Address: _____ Relationship: _____
Number Street/Unit City, State Zip Code

52. **Name**: _____ Phone Number: _____

Address: _____ Relationship: _____
Number Street/Unit City, State Zip Code

PREVIOUS PLACEMENTS: (If applicable: Include relative, foster, residential placements):

53. **Name**: _____ Phone Number: _____

Address: _____ Type of Placement: _____
Number Street/Unit City, State Zip Code

54. **Name**: _____ Phone Number: _____

Address: _____ Type of Placement: _____
Number Street/Unit City, State Zip Code

55. **Name**: _____ Phone Number: _____

Address: _____ Type of Placement: _____
Number Street/Unit City, State Zip Code

56. **Name**: _____ Phone Number: _____

Address: _____ Type of Placement: _____
Number Street/Unit City, State Zip Code

V. Education

57. Current/Last School: _____ Location: _____

58. Current/Last Grade: _____

59. Has child been classified as special needs? (Circle one) Yes No

If Yes, specify category: _____

60. IEP/504 Plan: (Circle one) Yes No

61. Check applicable school issues:

_____Inconsistent school attendance

_____Poor Academic Progress

_____Expulsion/Suspension

_____Truancy

_____Behavior Problems

_____Other,
Specify: _____

VI. Medical

62. Current Medical Issues: _____ 63. Allergies: _____

64. Date of Last Physical: _____ 65. Physician Name: _____
MM/DD /YYYY

66. Date of Last Dental Exam: _____ 67. Dentist Name: _____
MM/DD /YYYY

68. Name current medications: _____

VII. Other

If child's current family has DSS involvement, please indicate reason for involvement and/or removal:

Goal for Foster Care: Choose One

_____Return to Biological Family

_____Long Term Foster Care

_____Independent Living

_____Placement with Relative

_____Adoption

_____Other,
Specify: _____

Guardian Signature: _____ Date: _____