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 / APPLICATION

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 Use
_____Multi-Systemic Therapy
_____Therapeutic Foster Care
_____Intensive Therapeutic Foster Care
_____Outpatient Therapy
_____Intensive In-Home
_____Day Treatment
_____PRTF
_____iPRTF

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:_____ (Last / First / Middle) 2. Nickname: _____

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

4. Date of Birth:_____ (Month / Day / Year) Verified? Yes ____ No ____ 5. Gender: Female: ____ Male: ____

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:_____ (Last / First / Middle) 11. DOB: _____ (Month / Date / Year)

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

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: _____