



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.

- |  |   |
|--|---|
| <input type="checkbox"/> Comprehensive Clinical Assessment | <input type="checkbox"/> Outpatient Therapy |
| <input type="checkbox"/> Multi-Systemic Therapy            | <input type="checkbox"/> Day Treatment      |
| <input type="checkbox"/> Therapeutic Foster Care           | <input type="checkbox"/> PRTF               |
| <input type="checkbox"/> Intensive Therapeutic Foster Care | <input type="checkbox"/> iPRTF              |
| <input type="checkbox"/> Intensive In-Home                 |   |

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: \_\_\_\_\_