

# OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM REFERRAL FORM

**PLEASE PRINT in BLACK INK**

Reason _____	Area _____	Staff _____
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\_\_\_\_\_  
*Last* *First* *Middle*

\_\_\_\_\_  
*Sex* *Date of Birth*

\_\_\_\_\_  
*Address* *City* *Zip Code*

Asian       Black       Caucasian       Hispanic       Multi-racial

(W)  
(H)  
(Cell)

\_\_\_\_\_  
*Mother's Name*      *Address*      *City and Zip*      *Email*      *Phone*

(W)  
(H)  
(Cell)

\_\_\_\_\_  
*Father's Name*      *Address*      *City and Zip*      *Email*      *Phone*

(W)  
(H)  
(Cell)

\_\_\_\_\_  
*Step-Parent or Guardian*      *Address*      *City and Zip*      *Email*      *Phone*  
*(living with child)*

\_\_\_\_\_  
*Name of School*      *Grade*      *School District*      *Name of Local Youth Assistance Program*

**BRIEF DESCRIPTION OF REASON FOR REFERRAL** *(use additional sheets if necessary)*

★ **Upon acceptance of services, families will be assessed a \$25 processing fee** ★

Have other agencies or school services been involved?    Yes       No

If yes, who?

Is parent aware of referral?    Yes <input type="checkbox"/> No <input type="checkbox"/>	Is youth aware of referral?    Yes <input type="checkbox"/> No <input type="checkbox"/>
Has parent been informed of processing fee?    Yes <input type="checkbox"/> No <input type="checkbox"/>	

**Signature of Referring Person:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(signature required for processing)*

**Print Full Name and Job Title of Referring Person:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City and Zip Code:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Agency:** \_\_\_\_\_