Child & Family Focus, Inc.

Certified Peer Support for Transition Age Youth Referral

Young Person's Demographic Information

Name: _____ Referral Date: _____

Where do you live? _____

Where would you like to receive mail? _____

What is the best phone number to reach you at? _____

Who can I contact if I can't reach you?

First Name: _____ Relationship: _____ Phone: _____

Email Address: _____

Date of Birth: _____ Age Today: _____

I would like to be identified as: Female ☐ Male ☐ Intersex ☐ MtF Female ☐ FtM Male ☐

Social Security #: _____ Medical Assistance #: _____

Guardian(s) Name (if applicable): _____

Current School Attending (if applicable): _____

Current School District Attending (if applicable): _____

Are you working? Yes ☐ No ☐ If yes, is your employment Full-time ☐ or Part-Time ☐?

Are you experiencing housing instability? Yes ☐ No ☐

Mental Health History

Primary Mental Health Diagnosis Code and Description:

Additional Mental Health Diagnoses:

Primary Medical Diagnosis (if applicable):

Treatment History:

☐ **Currently placed in a crisis residential program**

☐ **3 or more crisis visits with walk-in or mobile crisis services in the last 2 years.**

☐ **6 months or more of continuous mental health treatment (i.e. individual therapy, group therapy and/ or medication management) in the last two years.**

☐ **6 months or more of mental health treatment provided by a primary care physician in the last two years.**

Referral Source's Information

☐ Youth/Young Adult/Self Referral

☐ Natural Support

Referring Person's Name:

Referring Person's Phone#:

Does the young person want to participate in CPS? Yes☐ No☐ Not Sure☐

☐ Formal Support

Name of Referring Person's Affiliation:

Referring Person's Name:

Referring Person's Phone#:

Does the young person want to participate in CPS? Yes ☐ No ☐Not Sure☐

System Involvement

☐ Mental Health Outpatient Involvement

If yes, Agency Name(s) & Contact Info:

☐ Probation Involvement

If yes, PO's Contact Info:

☐ Children & Youth Involvement

If yes, CYS Contact Info:

☐ Office of Intellectual Disabilities Involvement

If yes, OID Contact Info:

☐ Drug & Alcohol Treatment

If yes, D&A Contact Info:

The following MUST be answered by the Young Person Referred:

In 2-3 sentences, what do you expect from participating in the Peer Support Program?

Areas of Support:

☐ **Educational** ☐ **Vocational** ☐ **Social** ☐ **Life Skills Functioning**

***Please include, with this referral, a written recommendation from licensed psychiatrist, Primary Care Physician, psychologist, or CRNP that includes the diagnosis as well as a brief description of the functional impairment of the young person.**

I understand that submitting this referral does not guarantee enrollment into the program.

Youth/Young Adult's Signature **Date**

Referring Person's Signature (if applicable) **Date**

Please submit the completed referral and related materials to:

Child & Family Focus
Attn: Lori Harlan
2935 Byberry Rd Suite 108
Hatboro, PA 19040
Phone: 215-957-9771 ext 403
Fax: 215-957-9785
lharlan@childandfamilyfocus.org