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: Tiffany Thornton
450 Parkway Drive, Suite 208
Broomall, PA 19008
Phone: 610-325-3131
Fax: 610-325-3137
tthornton@childandfamilyfocus.org