

OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM REFERRAL FORM

PLEASE PRINT

Reason 	Area 	Staff
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Last *First* *Middle*

Sex *Date of Birth* *Social Security Number*

Address *City* *Zip Code*

Asian Black Caucasian Hispanic Multi-racial

(w)
(h)
(cell)

Mother's Name *Address* *City and Zip* *Phone*

(w)
(h)
(cell)

Father's Name *Address* *City and Zip* *Phone*

(w)
(h)
(cell)

Step-parent or Guardian *Address* *City and Zip* *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 No Is youth aware of referral? Yes No
 Has parent been informed of processing fee? Yes No

Signature of Referring Person: _____ **Date:** _____

(signature required)

Print Full Name of Referring Person: _____

Address: _____ City and Zip Code: _____

Telephone: _____ Agency: _____