

OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM REFERRAL FORM

PLEASE PRINT

Reason	Area	Staff

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 (living with child) _____ Address _____ City and Zip _____ Phone _____

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)

Print Full Name of Referring Person: _____

Address: _____ City and Zip Code: _____

Telephone: _____ Agency: _____