

APS # _____
W/L Auth until _____

Assigned to _____
Reg APS _____

YOUTH & FAMILY SERVICES, INC.
Children's Targeted Case Management
REFERRAL /BRIEF ASSESSMENT

Referral Date: _____

Individual Requesting Service: _____ **Relation to Child:** _____

Demographics of Child: Name: First _____ MI ____ Last _____

DOB: _____ SS# _____ Maine Care # _____

Child's Current Residence (Address where child will receive services)

Street: _____ Town: _____ Zip _____

Phone: _____ Cell _____

Legal Guardian & Mailing Address:

Name: _____

Guardian(s) Custody

Mailing Address: _____

Married ____ Sole ____

Shared ____ DHHS ____

Phone: _____ Cell: _____

Own ____

Primary Diagnosis : MR/Autism MH CAFAS Score _____ Date of last score _____

Axis I: _____ Axis II: _____

Presenting Problems: _____

Has Crisis been involved? Yes No If yes, explain: _____

Issues requiring additional assessments: _____