Phone: (207) 474-8311
FAX: (207) 474-5148
TTY: (207) 474-9894
Toll Free: 1-888-420-9605

YOUTH & FAMILY SERVICES, INC. 5 Commerce Dr., Skowhegan, ME 04976-0502

A Non-Profit Organization Serving Youth & Families
A Participating Agency of the United Way

FAMILY TEAM REFERRAL

Family Team Program

FAX #474-5148

SERVICE COORDINATOR REFERRAL FORM

In the interest of providing the best treatment services for the family referring, please take a moment to fill out the requested information; use back of form if necessary. This will become part of the client file.

NAME OF SERVICE
COORDINATOR: ____________________ AGENCY NAME: __________________
ADDRESS: ______________________________
______________________________ PHONE: ______________________________

Name of Referred Child: ______________________________________
D.O.B. __________________
Referral Date: _________ Telephone: ___________ MaineCare # _____________
S.S.I.# ___________
Address:
____
____

Other Family Member's Names	D.O.B.	Relationship

Revised 02/06/04

Significant Others:

Primary Reason for Referral (use the back of this page if more space is needed:

Goals you wish to be pursued by the Family Team Program and the family:

Do family members need substance abuse or psychological evaluation? [ ] Yes [ ] No
If "Yes", explain: Note: If any evaluations have been completed, please forward a copy.

Is this an open Department of Human Services case? [ ] Yes [ ] No If "yes":
Case Worker: ____________________________________ Office Location: ____________________

Is there any know physical or sexual abuse? [ ] Yes [ ] No Is "yes", explain:

Is there any suicidal or runaway history? [ ] Yes [ ] No If "yes", explain:

What are the school concerns? ____

Has the child been hospitalized? [ ] Yes [ ] No When: ______________________________________

Is the child on any medication? [ ] Yes [ ] No Please list: ____________________________________

Are there any conditions you are placing on the family in relation to their participation in the Family Team Program? [ ] Yes [ ] No If "yes", explain:____

Please indicate the level of your concern: 1=no concern 10=high concern

Concerns with the use of substances 1 – 10 ______
Concerns with family violence 1 – 10 ______
Concerns for physical discipline 1 – 10 _____
Is this family motivated to change? __yes ___no Explain: ______________________________

Your continuing role and case plan with the youth and family will be:

Revised 02/06/04

The eight mandatory criteria for acceptance of a referral are listed below. Please check and write additional information if needed:

Yes No
[ ] [ ] A child or other family member is at risk of leaving or being placed outside the home.

____

[ ] [ ] At lease one parent will be actively involved in treatment with the Team.

____

[ ] [ ] Other less intensive resources (outpatient counseling, school-based counseling, etc.) have been attempted and failed to bring change.

____

[ ] [ ] Other forms of traditional/office-based counseling or alternative programs do not exist in the area or are not available or are not appropriate.____

[ ] [ ] The referred family is willing to allow the Team to come to their home and are currently available to receive services.

[ ] [ ] The referral agent will be actively involved in case planning with the Family Team.

____

[ ] [ ] Is there a history of assaultive violence by any family member? Please describe past or present.

____

[ ] [ ] Has there been Family Team involvement with the family (other than assessment) previously?

____

What days/times are the family available to meet with the Team) i.e., any conflict of work, school schedules, Etc.):

____