

OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM  
**REFERRAL FORM**

**PLEASE PRINT**

Reason	Area	Staff

\_\_\_\_\_ Last First Middle

\_\_\_\_\_ Sex Date of Birth

\_\_\_\_\_ 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: \_\_\_\_\_