## OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM Reason Staff Area **REFERRAL FORM** PLEASE PRINT Last First Middle Date of Birth Sex Social Security Number Address City Zip Code Asian $\square$ Black Caucasian Hispanic Multi-racial (w) (h) (cell) Mother's Name City and Zip Address Phone (w) (h) (cell) Father's Name City and Zip Address Phone (w) (h) (cell) Step-parent or Guardian City and Zip Phone Address (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 $\square$ No $\square$ If yes, who? Is parent aware of referral? Yes No $\square$ Is youth aware of referral? Yes $\square$ No $\square$ Has parent been informed of processing fee? Yes Signature of Referring Person: \_\_\_\_\_ Date: \_\_\_\_ (signature required) **Print Full Name of Referring Person:** City and Zip Code: Address: Telephone: Agency: