

**Youth Service requested:**

- |                                                                           |                                                                 |
|---------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Youth Behavioral Health Assessment               | <input type="checkbox"/> Adolescent Substance Abuse             |
| <input type="checkbox"/> Functional Family Therapy (FFT)                  | <input type="checkbox"/> After-Hours Individual Counseling      |
| <input type="checkbox"/> Functional Family Therapy-Child Welfare (FFT-CW) | <input type="checkbox"/> Trauma-Focused Therapy                 |
| <input type="checkbox"/> Homebuilders                                     | <input type="checkbox"/> YouthBuild                             |
| <input type="checkbox"/> Pathways (Juvenile Sexual Offender)              | <input type="checkbox"/> Parenting Group (Partner in Parenting) |
| <input type="checkbox"/> Multisystemic Therapy (MST)                      | <input type="checkbox"/> Other:                                 |

**YOUTH DEMOGRAPHIC INFO**

<b>Name:</b>	<b>Medicaid:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicaid #:</b>	
<b>Social Security #:</b>	<b>Birthdate:</b>	<b>Age:</b>	<b>Race:</b>
<b>School:</b>	<b>Grade:</b>	<b>Gender:</b>	

**PARENT / CAREGIVER INFO**

<b>Parent/Guardian:</b>	<b>Main Phone:</b>
<b>Address:</b>	<b>Secondary Phone:</b>
I have been informed of the services I am being referred to. <input type="checkbox"/> Yes <input type="checkbox"/> N/A	

**REFERRING AGENCY**

<b>Name:</b>	<b>Phone:</b>
<b>Address:</b>	<b>Fax:</b>
<b>Contact Person:</b>	<b>Referral Date:</b>
<b>Email:</b>	
<b>Current Service Provider:</b>	
<b>Attached:</b> <input type="checkbox"/> Assessment <input type="checkbox"/> Plan of Care <input type="checkbox"/> Member's Choice Form/Freedom of Choice Form <input type="checkbox"/> Other:	
<b>Current Diagnosis:</b>	
<b>Description of Behavior and Concerns/Expected Outcome:</b>	

Please contact us with any questions at 985-266-1028 and please email referrals to [houmareferrals@startcorp.org](mailto:houmareferrals@startcorp.org)

**For office use only:**

