OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM
REFERRAL FORM

PLEASE PRINT IN BLACK INK

Reason | Area | Staff

_____ _____ _____
Last   First   Middle

_____ _____ _____
Sex   Date of Birth   Parent / Guardian Email

_____ _____ _____
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)*

Is LAW ENFORCEMENT involved with this referral?	Have other agencies or school services been involved?
Yes ☐ No ☐	Yes ☐ No ☐
If yes, who?	If yes, who?

Is parent aware of referral? Yes ☐ No ☐	Is youth aware of referral? Yes ☐ No ☐

Signature of Referring Person: /s/ _____ **Date:** _____
(automatic signature)

Print Full name of Referring Person: _____ **Email:** _____

Address: _____   City and Zip Code: _____

Telephone: _____   Agency: _____

01/31/2023