Justice Works YouthCare :Initial Referral & Assessment Form

Please send referral directly to JusticeWorks

JusticeWorks Contact Information: Katie Kirk
Ph: (717) 688-1146
e-mail: kkirk@justiceworksyouthcare.com

DIRECTIONS: Complete all fields

☐ **Cumberland County**

☐ **Truancy Remediation (WhyTry)**

Be sure to enter the SSN number for the TARGET/IDENTIFIED child only.

SSN # _____ **START DATE:** _____

FAMILY DEMOGRAPHICS

Identified Client: _____ **D.O.B:** _____ **Age:** _____

SEX: ☐ **M** ☐ **F** **Language:** _____ **Race:** _____ **Phone:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Client resides with (name): _____ **Relationship to child:** _____

List all persons residing in the home:

Please place an * next to the identified children

Name	Age / DOB/	Relationship to identified child

COMMUNITY INFORMATION

School: _____ Grade: _____

Phone: _____

REFERRAL INFORMATION

CURRENT RISK FACTORS In the home: check all that apply

☐ **Physical Abuse**	☐ **Drug/Alcohol Use**	☐ **Homicidal/Suicidal**	☐ **Runaway**
☐ **Sexual Abuse**	☐ **Delinquent Behaviors**	☐ **Legal Problems**	☐ **Neglect**
☐ **Mental Illness**	☐ **Antisocial Behaviors**	☐ **Negative Peer Influence**	☐ **Truancy**
☐ **Problems w/ Authority**	☐ **Parent/Child Conflict**	☐ **School Behavior/Performance**	

☐ **Other:** _____

CAREGIVER CAPACITY : please check appropriate

Mental/Physical/Behavioral stability	☐ **strength**	☐ **need**
Supervision in home	☐ **strength**	☐ **need**
Organization skills	☐ **strength**	☐ **need**
Resources/supports	☐ **strength**	☐ **need**
Residential stability	☐ **strength**	☐ **need**
Transportation	☐ **strength**	☐ **need**
Follow through abilities	☐ **strength**	☐ **need**

Currently working ☐ **Y** ☐ **N** **Education level: HS diploma/GED** ☐ **Y** ☐ **N** **Other:**

ASSISTANCE & SERVICES for:

☐ **Anger management**	☐ **Drug & Alcohol tx.**	☐ **Communication skills**
☐ **Parenting skills**	☐ **Vocational Training**	☐ **Housing**
☐ **Food**	☐ **Cash Assistance/welfare**	☐ **Marriage counseling**
☐ **Financial planning**	☐ **Independent living skills**	☐ **Support groups for MH**

☐ **Medical Services for:**

☐ **School intervention/alternative schooling programs**

REASON FOR REFERRAL (please include info on current situation/ brief synopsis. You may also fax the Family Service Plan if avail.):

GOALS FOR FAMILY:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.