OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM
REFERRAL FORM

PLEASE PRINT IN BLACK INK

Staff _____
Area _____
Reason _____

Last | *First* | *Middle*

Sex | *Date of Birth* | *Parent / Guardian Email*

Address | *City* | *Zip Code*

Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Multi-racial ☐

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 (living with child) | *Address* | *City and Zip* | *Phone* (w) (h) (cell)

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