Child & Family Focus, Inc.

Certified Peer Support for Transition Age Youth (age 14-26) Referral

***Delaware County referrals must also include an OBH Central Referral Form**

Referral Information

Referral Date: _____

Is the young person in agreement with a CPS referral being submitted on their behalf?
Yes ☐ **No** ☐

Young Person's Demographic Information

Preferred Name: _____
Birth Date: _____
Gender Identity: _____
Social Security #: _____
Phone Number: _____
Email Address: _____

Birth Name: _____
Medical Assistance #: _____
Preferred Pronouns _____
Race: _____
Address: _____
_____

Caregiver's Contact Information

Name(s): _____
Phone Number: _____
Email Address: _____

Relationship to the YP: _____
Address: _____
_____

Does the Young Person give permission for the CPS Program to contact this person to discuss the referral for CPS Services? Yes ☐ **No** ☐

Information about the Young Person

Current School Attending (if applicable):

Current School District Attending (if applicable):

Is the YP working? Yes ☐ No ☐
If yes, employment status: Full-time ☐ or Part-Time ☐

Is the YP experiencing housing instability? Yes ☐ No ☐

If yes, please explain: _____

Mental Health History

Primary Mental Health Diagnosis (Include DSM V Code):

Secondary Mental Health Diagnosis (Include DSM V Code):

Additional Mental Health Diagnoses (Include DSM V Code):

Treatment History (check all that apply):

☐ YP is currently placed in a Residential Treatment Facility or Inpatient Treatment Facility
If so, anticipated discharge date: _____

☐ YP has had THREE (3) or more crisis visits either by walk-in or mobile crisis services in the last two years.

☐ YP has had SIX (6) months or more of continuous mental health treatment (i.e., individual therapy, group therapy and/ or medication management) in the last two years.

☐ YP has had SIX (6) months or more of mental health treatment provided by a primary care physician in the last two years.

Referral Source's Information

☐ **Self-Referral**

☐ **Referral by Natural Support**
Affiliation with the Young Person:

Referring Person's Name:

Referring Person's Phone #:

Does the young person want to participate in CPS? Yes ☐ No ☐ Not Sure ☐

☐ **Referral by Formal Support**
Affiliation with the Young Person:

Referring Person's Name:

Referring Person's Phone #:

Does the young person want to participate in CPS? Yes ☐ No ☐ Not Sure ☐

Systems Involvement

☐ **Mental Health Treatment Involvement**
If yes, Agency Name(s) & Contact Info:

☐ **Probation Involvement**
If yes, PO's Name(s) & Contact Info:

☐ **Children & Youth Services Involvement**
If yes, CYS Name(s) & Contact Info:

☐ **Office of Intellectual Disabilities Involvement**
If yes, OID Name(s) & Contact Info:

☐ **Drug & Alcohol Treatment Involvement**
If yes, D&A Name(s) & Contact Info:

To be answered by the Young Person:

Areas of support to be targeted during the delivery of CPS Services (check all that apply):

☐ **Self-Maintenance/Daily Living Skills**

- ☐ Resiliency/Recovery Planning
- ☐ Identification of Community Supports
- ☐ Educational/Vocational Support
- ☐ Social Development
- ☐ Transitional Planning/Independent Living
- ☐ Other – Specify: _____

What service goals to you wish to accomplish while receiving Peer Support Services?

Attestation and Signatures:

I understand submitting this referral does not guarantee enrollment of the young person into the CPS program. Upon review, the administrative team will contact the young person or designated caregiver to discuss eligibility.

Young Person's Signature **Date**

Referring Person's Signature (if applicable) **Date**

Please submit the completed Referral and LPHA forms to:
Nikki Kline, MA-MT, TAY CPS Program Director
nkline@childandfamilyfocus.org

If you have any questions, please contact the TAY CPS program at 215-957-9771 ext. 403