OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM
REFERRAL FORM

Reason	Area	Staff

PLEASE PRINT

Last *First* *Middle*

Sex *Date of Birth* *Social Security Number*

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 (living with child) *Address* *City and Zip* *Phone*

Name of School *Grade* *School District*

Name of Local Youth Assistance Program

BRIEF DESCRIPTION OF REASON FOR REFERRAL *(use additional sheets if necessary)*

●Upon acceptance of services, families will be assessed a $25 processing fee●

Have other agencies or school services been involved? Yes ◯ No ◯
If yes, who?

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

Has parent been informed of processing fee? Yes ◯ No ◯

Signature of Referring Person: _____ **Date:** _____
(signature required)

Print Full Name of Referring Person: _____

Address: _____ City and Zip Code: _____

Telephone: _____ Agency: _____

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