CUMBERLAND COUNTY YOUTH SERVICES COMMISSION REFERRAL FORM

(Revised 1/2024)

Note: Please submit completed form to requested service agency(s) listed for services below.

Please CC samuelwi@CumberlandCountyNJ.gov and julieco@CumberlandCountyNJ.gov with your submission.

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |       | Referring Agency: |       |
| Name of Referring Person: |       | Phone:  |       |
| Deferred Disposition: |       | Disposition: |       | Disposition Date: |       | Length of Term: |       |
| Court Ordered: | [ ]  Yes [ ]  No | Term Expiration Date: |       |
| DCP&P Involvement: | [ ]  Yes [ ]  No [ ]  Unknown | [ ]  Hearing [ ]  Sentencing Date: |       |
| Client Name: |       | Sex: |       | DOB: |       | Age: |       | Race: |       |
| Current Address: |       |
| Home Phone: |        | Cell Phone: |       | Language(s) Spoken: |       |
| School Currently Attending: |       | Phone: |       |
| Reason for Referral: |       |
|       |
| Names of persons currently living with juvenile: |
| Name |  | Relationship |  | Age |  | Name |  | Relationship |  | Age |
|       |  |       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |  |       |

|  |
| --- |
| SERVICES REQUESTED – CHECK ALL THAT APPLY |

|  |  |  |
| --- | --- | --- |
| DIVERSION(MRSS/FCIU, JCC, FAMILY COURT, LAW ENFORCEMENT, SCHOOLS) | DISPOSITION(JUVENILE PROBATION, FAMILY COURT) | DETENTION |
| [ ]  SEXTING INTERVENTION PROGRAMSubmit to: paso@centerffs.org  veronica.ramos-cruz@centerffs.org  vconnelly@centerffs.org  856-408-3047 Ext. 22151 | [ ]  COGNITIVE SKILLS PROGRAMSubmit to: julieco@cumberlandcountynj.gov  856-459-3083 | [ ]  IN-HOME DETENTION (FAMILY COURT)Submit to: mhamidy@yapinc.org  856-691-1540 |
| [ ]  DRUG & ALCOHOL EVALUATIONSubmit to: sharonme@cumberlandcountynj.gov  856-451-3727 | [ ]  IN-HOME COUNSELINGSubmit to: mkdavis@acendahealth.org  609-425-8088 |  |
| [ ]  DRUG & ALCOHOL TREATMENTSubmit to: sharonme@cumberlandcountynj.gov  856-451-3727 | [ ]  SEX OFFENDER EVALUATIONSubmit to: paso@centerffs.org  856-408-3047 Ext. 22151 |  |
| [ ]  INDIVIDUAL MENTORINGSubmit to: taviaus@unitedadvocacygroup.org  856-506-7430 | [ ]  SEX OFFENDER TREATMENTSubmit to: paso@centerffs.org  856-408-3047 Ext. 22151 |  |
| [ ]  IN-HOME COUNSELINGSubmit to: mhamidy@yapinc.org  856-691-1540 | [ ]  DRUG & ALCOHOL EVALUATIONSubmit to: sharonme@cumberlandcountynj.gov  856-451-3727 |  |
|  | [ ]  DRUG & ALCOHOL TREATMENTSubmit to: sharonme@cumberlandcountynj.gov  856-451-3727 |  |
|  | [ ]  INDIVIDUAL MENTORINGSubmit to: mhamidy@yapinc.org  856-691-1540 |  |

|  |  |
| --- | --- |
| [ ]  Parent/ [ ]  Guardian [ ]  Foster Parent’s Name: |       |
| Address (if different from child’s): |       |
| Work Phone/Employer: |       | Work Hours: |       |
| Are caretakers aware that this referral is being made for services?  |       | Is transportation needed? |       |
| Emergency Contact: |       | Relationship: |       |
| Home Phone: |       | Work Phone: |       |  |
|  |
| **SCHOOL INFORMATION** |
| Last/Current School: |       | School Phone: |       |  |
| Classification: |       | CST Evaluation: | [ ]  Yes [ ]  No | Grade: |       |  |
| Reason for Referral/Issues: |       |  |
|  |       |  |
|  |       |  |
|  |
| **EXISTING FACTORS OF JUVENILE’S PRESENT/PAST HISTORY (Check all that apply)** |
| [ ]  Actively Rejecting Help | [ ]  Inadequate Supervision | [ ]  Poor Frustration Tolerance |
| [ ]  Alcohol Abuse | [ ]  Inappropriate Discipline | [ ]  Poor Interpersonal Skills |
| [ ]  Alcohol Dependence | [ ]  Inconsistent Parent Figure | [ ]  Poor Problem Solving Skills |
| [ ]  Antisocial/ Pro-criminal Attitudes | [ ]  Inflated Self-Esteem | [ ]  Poor Relationship - Parent Figure |
| [ ]  Attention Deficit/Hyperactivity Disorder | [ ]  Lack of Independent Living Skills | [ ]  Poor School Performance |
| [ ]  Callous, Little Concern for Others | [ ]  Lack of Job Skills | [ ]  Post-Traumatic Stress |
| [ ]  Criminal Behavior - Family | [ ]  Lack of Remorse | [ ]  Repeated Suspensions |
| [ ]  Defies Authorities | [ ]  Lack of Teen Parenting Skills | [ ]  Runaway Behavior |
| [ ]  Delinquent Friends | [ ]  Lack of Vocational/Technical Skills | [ ]  Serious Mental Illness |
| [ ]  Difficulty in Controlling Youth’s Behavior | [ ]  Low Self-Esteem | [ ]  Sexually Acting Out |
| [ ]  Disruptive Behavior in School | [ ]  Marital Conflict - Parents | [ ]  Short Attention Span |
| [ ]  Domestic Violence in Family | [ ]  Medical Problems/Family | [ ]  Substance Abuse - Family |
| [ ]  Dropout | [ ]  Medical Problems/Juvenile | [ ]  Suicide Ideation/Gestures |
| [ ]  Drug Abuse | [ ]  Mental Illness - Family | [ ]  Teen Pregnancy |
| [ ]  Drug Dependence | [ ]  Neglect - Juvenile | [ ]  Truancy |
| [ ]  Family Exposure to Community Violence | [ ]  No/Few Positive Friends | [ ]  Verbally Aggressive |
| [ ]  Functioning Below Grade Level | [ ]  Physically Aggressive | [ ]  Victim of Physical Abuse - Juvenile |
| [ ]  Illiteracy | [ ]  Poor Anger Management | [ ]  Victim of Sexual Abuse/Incest - Juvenile |
| [ ]  Other: |       |
| Medical Issues: |       |
| Family Physician: |       | Phone: |       |
| Allergies: |       | Current Medications: |       |
| [ ]  Medicaid [ ]  Private Health Insurance: |       |
| Juvenile is not to have contact with the following persons: |       |
| PERFORMCARE |
| Were the services requested sought through PerformCare before submitting this referral?  | [ ]  Yes [ ]  No |
| IF NO, WHY NOT? |
|       |
| IF YES, WHY IS THIS REFERRAL BEING SUBMITTED? |
|       |
| DATE OF CALL:        | TIME OF CALL:       | LENGTH OF CALL:       |

|  |
| --- |
| PARENTS / GUARDIANS |
| Has the youth’s parent / guardian been informed that this referral for services is being submitted? | [ ]  Yes [ ]  No |
| IF NO, WHY NOT? |
|       |