

Date Received _____ CET Criteria: Home / School / Funding Request / Staffing Date/Time Scheduled _____



Community Evaluation Team (CET) Referral Form

Please Complete and Submit to:

Indra Briedis, CET Coordinator
Phone/Fax: 970-625-2204 Email: ibriedis@youthzone.com
c/o YouthZone, 136 East 12th Street, Rifle, CO 81650

Referral Source (name and contact information) _____

Youth's Name _____ **DOB** _____ **Age** _____ **Sex** _____ **Race/Ethnicity** _____

Home phone # _____

Physical address _____

Mailing address, if different _____

Youth currently living with _____

Parent's Name (#1) _____ Please circle: biological/step/adoptive/foster

Employer _____ Occupation _____ Work phone _____

Monthly gross income \$ _____ Cell phone _____ E-mail _____

Parent's Name (#2) _____ Please circle: biological/step/adoptive/foster

Employer _____ Occupation _____ Work phone _____

Monthly gross income \$ _____ Cell phone _____ E-mail _____

Others Living in the Home

Name _____ Age _____ Sex _____ Relationship to youth _____

Name _____ Age _____ Sex _____ Relationship to youth _____

Name _____ Age _____ Sex _____ Relationship to youth _____

Insurance and Public Assistance (please check all that are applicable)

- Medicaid
- CHP+
- WIC
- Food stamps
- HUD housing
- Private insurance _____
- Other _____

Youth's Education

School _____ Grade _____ School District (circle one) RE-1 / RE-2/ Dist. 16

Teacher's name and contact information _____

School counselor's name and contact information _____

Current grade point average (GPA) _____ Attendance (circle one): Poor / Fair / Good / Excellent

Does the youth have an individualized education plan (IEP)? (circle one) Yes / No

If yes, date _____ If yes, did the youth receive the designation of SIED? (circle one) Yes / No

Discipline issues (i.e. suspensions, expulsions) _____

Other comments/Concerns _____

Youth's Medical History (please check all that are applicable)

- Birth complications Medications (please list) _____
 Chronic physical problems Psychiatric issues Other _____

Other Agency Involvement (please check and describe all that are applicable)

Mental Health Services

<i>Past</i>	<i>Present</i>	<i>Type of Service</i>	<i>Name of Provider and Date of Services</i>
<input type="checkbox"/>	<input type="checkbox"/>	counseling/therapy	_____
<input type="checkbox"/>	<input type="checkbox"/>	psychiatric evaluation	_____
<input type="checkbox"/>	<input type="checkbox"/>	psychological evaluation	_____
<input type="checkbox"/>	<input type="checkbox"/>	drug/alcohol therapy	_____
<input type="checkbox"/>	<input type="checkbox"/>	drug/alcohol inpatient	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

Legal Involvement

<i>Past</i>	<i>Present</i>	<i>Type of Service</i>	<i>Nature of involvement and dates</i>
<input type="checkbox"/>	<input type="checkbox"/>	Municipal court	_____
<input type="checkbox"/>	<input type="checkbox"/>	County court	_____
<input type="checkbox"/>	<input type="checkbox"/>	District court	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diversion	_____
<input type="checkbox"/>	<input type="checkbox"/>	Probation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Detention	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

Other Services

<i>Past</i>	<i>Present</i>	<i>Type of Service</i>	<i>Nature of involvement and agency contact person</i>
<input type="checkbox"/>	<input type="checkbox"/>	Dept. of Human Services	_____
<input type="checkbox"/>	<input type="checkbox"/>	YouthZone	_____
<input type="checkbox"/>	<input type="checkbox"/>	Advocate Safehouse	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

Family History (please check all that are applicable and describe)

- mental health issues _____
- substance abuse (drug/alcohol) _____
- domestic violence _____
- parental criminal behavior _____
- other _____

Please describe any other concerns or comments that have not been previously addressed that you feel would be helpful to share with the CET. This would include any supportive services that are already in place or will begin in the near future.

If the youth meets CET criteria for funding assistance, what services would you like to see put into place for the youth and his/her family members? Please provide the following information:

- 1) Requested Service**
Name of service provider (if known) _____
Phone # and address of service provider _____
Duration of service _____
Cost of service _____

- 2) Requested Service**
Name of service provider (if known) _____
Phone # and address of service provider _____
Duration of service _____
Cost of service _____

- 3) Requested Service**
Name of service provider (if known) _____
Phone # and address of service provider _____
Duration of service _____
Cost of service _____

- 4) Requested Service**
Name of service provider (if known) _____
Phone # and address of service provider _____
Duration of service _____
Cost of service _____