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*

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? Yes ☐ No ☐ If yes, who?	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 ☐

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