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 ☐

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* (w) (h) (cell)

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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