Youth Homes

DAN FOX FAMILY CARE PROGRAM

Home Support Services Referral

Please submit this application and any additional documents (including a release of information for all team members, evaluations, and other pertinent information) to **Katelyn Scholle** via email (kscholle@youthhomesmt.org) or fax (543-0356). Once we receive this information, we will contact you and the family to ask additional information as needed. We review our referrals every Monday. After the referral is reviewed and accepted, we will contact the family to arrange an intake meeting and start services. **If you have any questions, please call Katelyn Scholle at 541-1663.**

Child Name:
Date of Birth:
Social Security Number:
Sex:
Race:
Insurance:
Medications:

Who does the child currently live with?
Phone number and address:
Mother:
Father:
Other parental figure:
Siblings:

Person making referral (name and contact information):
Therapist (name and contact information):
Other team members:
Diagnosis:

Current school:
Grade:
Special needs (IEP, CSCT, etc.):
Summary of school functioning:

Behaviors/issues that you are concerned with:

Problems in family and/or trauma history:

Previous placements (including dates and reason for discharge):

Reason for referral: