

## Community Based REFERRAL FORM

This form is to be completed by the agency of referral and returned to Partners:

**Fort Collins/Loveland:** Abby Rains at 530 S. College Ave. Fort Collins, CO 80524 or [arains@poweredbypartners.org](mailto:arains@poweredbypartners.org) (970) 484-7123.

**Greeley:** Christopher Briotte, 710 11<sup>th</sup> Ave., Ste. 106, Greeley, CO 80631 or [cbriotte@poweredbypartners.org](mailto:cbriotte@poweredbypartners.org) 970-378-6501

**Estes Park:** Kathy Whitacre, PO Box 484, Estes Park, CO 80517 or [kwhitacre@poweredbypartners.org](mailto:kwhitacre@poweredbypartners.org), 970-577-9348

Information will be kept confidential and will be used to assist the Program Coordinator in matching the child with an appropriate Senior Partner. **Please take the time to fill in all information completely.**

Date: \_\_\_\_\_ Date Received: \_\_\_\_\_ Referral # \_\_\_\_\_

Referring Agency: \_\_\_\_\_ Referring Person: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### **YOUTH INFORMATION**

NAME: \_\_\_\_\_

GENDER: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ ETHNICITY: \_\_\_\_\_

Name(s) of Parent(s)/Guardian(s) living in the home: \_\_\_\_\_

Name(s) of Parent(s)/Guardian(s) outside of the home if applicable: \_\_\_\_\_

Phone: \_\_\_\_\_ EMAIL: (if known) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Language spoken in the home \_\_\_\_\_

Brothers/sisters and significant others in the home (please include ages of each):

Name: \_\_\_\_\_ age: \_\_\_\_\_

Name: \_\_\_\_\_ age: \_\_\_\_\_

Name: \_\_\_\_\_ age: \_\_\_\_\_

Name: \_\_\_\_\_ age: \_\_\_\_\_

Please describe the youth's behavior at home, if known:

**Youth's attitude toward self:**    Very good                      Good                      Fair                      Poor

### **School Information**

SCHOOL: \_\_\_\_\_ GRADE \_\_\_\_\_ INTEGRATED SERVICES \_\_\_\_\_ Student ID# \_\_\_\_\_

School Counselor/Social Worker/ Other \_\_\_\_\_ Phone: \_\_\_\_\_

Risk Factor	Youth	Family	Past	Present	Please explain if applicable:
Constant Relocation					
Delinquency (not legally involved)					
Disability (Physical, Learning, Mental, etc.)					
Domestic Violence					
Emotional/Verbal Abuse					
English as Second Language					
Gang Affiliation					
Homelessness					
Substance Abuse/Dependency					
Legal Issues					
Low Income					
Mental Health Concerns					
Out of Home Placement					
Neglect					
Incarceration					
Parent/Sibling Death/Suicide					
Physical Abuse					
Poverty					
Sexual Abuse					
Suicide Attempts					
Victim of Bullying					

**YOUTH BEHAVIOR IN SCHOOL:** Issues or behavior patterns affecting the youth's school success. (Check all that apply)

<input type="checkbox"/>	Low Grades
<input type="checkbox"/>	Learning Disability
<input type="checkbox"/>	Poor Attendance
<input type="checkbox"/>	Poor Peer Relations
<input type="checkbox"/>	Aggressive/Fighting
<input type="checkbox"/>	Defiant of Authority
<input type="checkbox"/>	Disrupts Classroom

<input type="checkbox"/>	Overly dependent on peers
<input type="checkbox"/>	Overly dependent on Adults
<input type="checkbox"/>	Quiet/Withdrawn
<input type="checkbox"/>	Experiments with Drugs/Alcohol
<input type="checkbox"/>	Destructive
<input type="checkbox"/>	Fearful/Anxious
<input type="checkbox"/>	Emotional Outbursts

What are the youth's greatest strengths?

Is there any other information that would be helpful for a mentor to know?

**Recommendation for Matching:** What kind of person would work best with this youth?

PARENT PERMISSION  
**To Refer Youth to Partners**

I \_\_\_\_\_ Parent/Guardian/Custodian (circle one) of

\_\_\_\_\_, do hereby give permission for  
Youth's name

\_\_\_\_\_ to nominate \_\_\_\_\_ for participation  
Referral Agent Youth's name

in the Community Based Mentoring Program provided by Partners.

Recommendations to this program are given through written referral by school staff or other youth serving organizations/individuals such as counseling professionals, and require the release of academic, family, and social background of the youth to Partners. Information shared will be kept to the minimum necessary for rendering effective services. By signing this form, I give my consent for the sharing of such information between the referral agent, Partners and my child's mentor if matched.

I understand that there is no guarantee that my child will be accepted into the program after he/she has been referred.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Youth's Name

\_\_\_\_\_  
Phone # (if different than guardians, Cell #)

Partners treats all people with dignity and respect, regardless of race, religion, gender identity, disability, sexual orientation, nationality, country of origin, or belief system. We will not discriminate based on any of these factors and will continue to advocate for and provide quality services to all who need them.