Please send referrals to:
Intake Coordinator – Kerry Buckman

Collier House
386 Maple Place
Keyport, NJ 07735

Phone: 732-264-3222-direct line**

Fax: 732-264-3277

Collier House

REFERRAL FORM

Client's name:_____ D.O.B. _____ Date of referral_____

S.S. #: _____ Referral Source: _____DYFS/ KC #:_____

Contact Person:_____ Telephone:_____ Ext:_____

***The appropriate candidate for the Collier House should be between the ages of 18-21, homeless or aging out of the child welfare system, and possess the following attributes: (1)Desires to reach potential and attain productive self-sufficiency; (2) Expresses an interest in developing life skills needed to facilitate independent living; (3)Demonstrates respect for self, others and property; (4)Expresses an interest in pursuing and/or maintaining viable employment, educational or vocational pursuits.**

A. Current Living Status:

☐Resource Family ☐Group Home ☐Shelter

☐Other (explain)_____

Name of Facility/Group Home/Shelter/Foster Home: _____

Present Address: _____

_____

Home Telephone: _____ Work Telephone: _____

**For youth currently residing in residential or treatment home settings, we request you include their most recent treatment plan, psychological evaluation, and discharge summary.*

B Please discuss the applicant's strengths, which indicate the ability to function independently with supportive services:

_____
_____
_____
_____
_____
_____
_____
_____

C. Please discuss any challenges the applicant may have which impedes his/her ability to function independently: (i.e. not taking prescribed psychiatric medications, current substance abuse, cognitive impairments, criminal conviction in past 5 years, behavioral problems, present a danger to themselves or others, fire-setter):

D. List All Family Members and Significant Others

Name	*Address*	*Telephone#*	*Age*	*Relationship to Client*

E. Placement History: (Include present placement)

Placement	*Contact Person*	*Dates*

F. School Information:

School: _____ Most Recent grade completed: _____

Classification (please specify e.g. MH, ED,...) _____

CST Evaluation: ☐Yes ☐No

G. Youth Income:

(1) Under $5000 ☐ (2) $5,000- $9,999 ☐ (3) $10,000- $14,999 ☐

(4) $15,000- $24,999 ☐ (5) $25,000- $34,999 ☐ (6) $35,000 or more ☐

(7) SSI applied for? ☐ Yes ☐ No

(8)Receiving public assistance? ☐ Yes ☐ No

H. Is youth eligible for any of the following public assistance programs? If yes- please check box:

☐ GA/TANF ☐ Food Stamps ☐ SSI or SSD ☐ New Jersey Family Care ☐ WIC

1. Is youth currently receiving Medicaid? If yes, is it provided by the Division of Youth and Family Services, MEYA (Medicaid Extension for Young Adults) or social services?_____

_____

_____

2. Has this permanent housing program (with mandatory supportive services component) been discussed with potential resident? ☐ Yes ☐ No

3. Is the potential resident motivated to participate?

_____

_____

Additional Information Concerning Present Situation: _____

_____

_____

_____

_____

_____

Medical History of the Resident: (please indicate whether information is gathered by the Caseworker, Resident, Physician or School Records)

Chronic Conditoins:_____

_____**Past Serious Illnesses:**_____

_____

_____

Allergies:

_____

_____

_____

Medications that they take including vitamins:_____

_____

_____

Immunizations:

_____

_____

_____

Special Medical Diet:

_____

_____

_____

**** Indicate None if None**

Referral Agency's Assessment of Potential for Physical Violence Toward Others (including peers as well as staff)_____

_____

_____

_____

_____

Name of person completing this form:_____

*******After review of this form, a decision will be made if youth is eligible. If they are, youth will be contacted to come in for an interview. If youth is accepted, they will need to have a physical, hearing and vision screens prior to move-in.**

To be completed by Collier House Staff:

Screener's Disposition: _____ Date:_____

_____

(Screener's Signature)