SEND REFERRAL FORM TO:
ATTN: Latisha Owens • Guiding Light Mentoring
4141 Hamilton Avenue Suite #1 • Cincinnati, OH 45223
- OR - Email: info@guidinglightmentoring.org

YOUTH REFERRAL FORM

PLEASE PRINT

Child's Name_____ DOB_____ Age_____

SSN_____ School_____

Phone_____ Gender_____ Race_____ Grade_____

Address_____ Zip_____

Parent/Legal Guardian Information

Name_____ Relationship_____

Address_____ Zip_____
(If different than Child)

Phone *(Cell)*_____ *(Work)*_____

E-Mail Address_____

LIST MEMBERS OF CHILD'S CURRENT HOUSEHOLD

	Name:	Relationship	Age
1)			
2)			
3)			
4)			
5)			
6)			

Youth Information

Does the Child have Medicaid? YES☐ NO☐

If yes, list Medicaid insurance provider _____

Medicaid insurance number (12 digits)_____

Medicaid insurance member ID (11 digits)_____

Please include a copy of the Child's DAF and/or IEP

Referring Agency

Program Name_____ Phone_____

Referral Date_____ E-Mail_____

Agency/Program relationship to Child_____

Name of Referral Source _____ Title_____

Referral Reasons: *(check all that apply)*

☐ Positive Role Model	☐ Try New Activities	☐ Friendship Building	☐ Social Skills
☐ School Behavior	☐ Missing School	☐ Peer Conflict	☐ Family Conflict
☐ Emotional Support	☐ History of Abuse	☐ Domestic Violence	☐ Runaway
☐ Homeless	☐ Arrests/Legal Issues	☐ Drug/Alcohol	☐ Gang Related
☐ Impulse Control	☐ Hyperactivity	☐ Self-Esteem	☐ Body Image
☐ Eating Issues	☐ Grief/Loss	☐ Anxiety	☐ Depression
☐ PTSD	☐ Other:_____		

Description/Referral Reasons:

Any recent changes of the Child noticed?_____

_____

Any recent changes of Child's family or living situation?_____

_____

Any specific challenges or difficulties? *(what and when did they begin?)*_____

_____

Goals you believe would be good for the Child_____

_____

What could improve the Child's life?_____

_____

What would the Child say is reason for being referred?_____

_____

What would the Child see as a goal?_____

_____

Is the Child on a waiting list or enrolled in any other programs? YES☐ NO☐

Has this referral been discussed with the Child & Parent/Legal Guardian? YES☐ NO☐
(If made by someone other than Parent/Legal Guardian)

If yes, when?_____

What was their response/are they interested in receiving services? _____

_____

Programs

Program you are referring the Child to:

☐Mentoring Program ☐Case Management Services ☐Violence Prevention Program

☐Groups

All information included on this form will be kept confidential and is for agency use only.