**EXTENDED FOSTER CARE REFERRAL FORM**

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| **REFERRAL INFORMATION** | | | | |
| Date of Referral: | Young Adult Name: | | Date of Birth/Age: | |
| Gender Identity: | Race: | Hispanic: Y  N | TIPS#: | SSN: |
| Current Address:    Parish of Residence: | Telephone #: | Email Address: | Member of a Federally Recognized Tribe?  Yes  No  Legal US Citizen?  Yes  No | |
| Has the young adult been enrolled in EFC previously?  Yes  No  Does the young adult receive SSI?  Yes/Amount $       No  Does the young adult qualify for OCDD services?  Yes  No (If yes, attach Statement of Approval)  Does the young adult currently receive OCDD services?  Yes  No | | | | |
| Referral Regarding (please select one)  Extended Foster Care (if checked please answer):  Currently in Foster Care  Not Currently in Foster Care, Date of Exit | | | | |
| Court of Jurisdiction:  Docket #:  Has the 17 year old court report been submitted to the court?  Yes  No (If yes, attach court report) | | | | |

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| **REFERRING WORKER INFORMATION** |  |
| Referring DCFS Worker:  Worker’s Contact Number:  Parish and Region:  Office Number:  Worker TIPS#: | Referring DCFS Supervisor:  Supervisor’s Contact Number: |

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| **ELIGIBILITY (check all that apply)** |
| Adjudicated CINC  Aged out of foster care on 18th birthday  Under age 21  Completing secondary education or program leading to an equivalent credential  Enrolled in an institution that provides postsecondary or vocational education  Participating in a program or activity designed to promote employment or remove barriers  Employed at least 8- hours per month  Incapable of doing any part of the activities listed above due to a medically documented medical condition |

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| **EDUCATIONAL PROGRAM** |
| Name of School/HiSet/GED Program:  If in school, currently assigned grade level:  Anticipated Date of Graduation/Completion:  Enrollment Verification:  Attached  Pending |

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| **CURRENT LIVING ARRANGEMENT (select one)** | | | | **PLACEMENT PROVIDER INFORMATION** | |
|  | On Own |  | PRTF  Treatment Facility | Provider Name: | Provider Number: |
|  | Relative |  | Shelter |  |  |
|  | Foster Parent |  | Homeless | Provider Address: |  |
|  | TLP |  | TFC |  |  |
|  | Residential |  | Host Home | Provider Region: |  |
|  | Fictive Kin |  | With Roommates | Provider Phone:  Can the youth remain in this placement for the next six months?  YES  NO | |
| **IMMEDIATE NEEDS OF THE YOUTH** | | | | | |
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| |  | | --- | | **YOUTH’S PLAN FOR TRANSITION:** | | What does the youth want to do or plan live with when they turn 18? | | | | | | |
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**Please check all applicable:**

**Developmental Disability or Mental Retardation**

Current Diagnosis:        Unknown

Current Medical Provider:

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| **Serious Mental Health Issues**: ( Suicidal Ideation | | Suicidal Attempt | History of Cutting) |
| Current Diagnosis:  Current Medical Provider:  **Delinquency/Criminal Behavior** | Unknown |  |  |
| History within 3 years  Brief Description:    **Current Drug/Alcohol Abuse** | History within 1 year | Acute - history within 60 days | Unknown |
| History within 3 years  Brief Description:    **History of Physical Violence** | History within 1 year | Acute- history within 60 days | Unknown |
| History within 3 years  Brief Description: | History within 1 year | Acute- history within 60 days | Unknown |
| **Victim of Human Trafficking:** (Confirmed  Suspected ) | |
| History within 3 years  History within 1 year | | Acute- history within 60 days | Unknown |

Brief Description:

For Use by LifeSet Supervisor Approver Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved for EFC with LifeSet

Approved for EFC without LifeSet Date: \_\_\_     \_\_\_\_\_\_\_\_  Not Accepted into EFC

Reason:

Transfer date and time: