



Youth Aftercare Referral Packet

Youth Aftercare Referrals must include two copies of the following to complete your packet:

- Youth Aftercare Referral Form
- Signed Youth Aftercare Disclosure Form
- Most recent Case Plan
- Most recent Court Report
- Most recent Transition Plan
- Ansell Casey Assessment (NEW)
- Any other pertinent document that will provide an accurate assessment of the youth's progress in preparing for transition (i.e. mental health evaluations, substance abuse treatment progress reports, educational/vocational reports)

PLEASE NOTE
This application is for Youth Aftercare Referrals only. To apply for Rapid Housing you must complete a Rapid Housing application.

The Collaborative Council accepts Youth Aftercare Referrals once a month based on the youth's transition date. Once an Aftercare Worker has been assigned to the youth, the Collaborative Liaison Office will send an email to inform you of the assigned Collaborative.

Bring your Youth Aftercare Referrals (seven or fewer months prior to youth's transition date) to:

Child and Family Services Agency
Collaboratives Liaison Office
400 6th Street, SW #5083
Washington, DC 20024

For more information, or further assistance, please call (202) 715-7797.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency
Youth Aftercare Project



REFERRAL FORM

Date Submitted: _____
(For OYE Use ONLY)

Directions: Please complete this form in its entirety with the **most current information**. **Attach a Case Plan, ITILP/YTP, current court report and the youth's Ansell Casey Assessment**. It is **MANDATORY** that the youth **sign the authorization to refer and disclose information form** as a condition to participate in the program. Your referral is not complete unless **ALL** the above information is attached.

Name of Youth: _____ Client ID#: _____

DOB: _____ Date of Transition: _____

Current Placement: _____

Address: _____

Home Number: _____ Cell Phone #: _____

Work Number: _____

Name of Agency/Administration: _____

Social Worker: _____ Supervisor: _____

Office Phone #: _____ Office Phone#: _____

Cell Phone #: _____ Cell Phone #: _____

A. Educational Status: (Please check responses)

Does youth attend school? Yes No Grade _____
Name/Address of
School: _____
Does youth receive Special Education Services: Yes No
Is youth in Post Secondary Education/Training? Yes No
Name/Address: _____

B. Employment Status

Is youth currently employed? Yes No Part-Time Full-Time
Name/Address of Employer: _____

Telephone Number of Employer: _____

C. Center of Keys for Life

Has youth been referred to Center of Keys for Life? Yes No
Does youth attend Center of Keys for Life? Yes No
Does youth have an Independent Living Plan? Yes No

D. Health Information

Last Date of Physical: _____ Where? _____
Mental Health Diagnosis: _____
Medication: _____
Name/Phone # of Therapist: _____

E. List ALL supports youth needs to successfully transition from care:

1. _____
2. _____
3. _____
4. _____
5. _____

G. Name/Address of Significant Person in Youth's life who will assist youth towards the transition into Adulthood.

Name: _____

Address: _____

Telephone#: _____

The collaborative will facilitate the initial transition conference. In an effort to assist the collaborative staff in coordinating the transition conference please list the names, addresses and telephone numbers of all stakeholders that will attend the meetings. Please talk with your youth to obtain this information when obtaining a signature to disclose information.

1. Name/Relationship to Youth: _____

Address: _____

Telephone#: _____

2. Name/Relationship to Youth: _____

Address: _____

Telephone#: _____

3. Name/Relationship to Youth: _____

Address: _____

Telephone#: _____

4. Name/Relationship to Youth: _____

Address: _____

Telephone #: _____

5. Name/Relationship to Youth: _____

Address: _____

Telephone #: _____