**REFERRAL REQUEST FOR FAMILY/YOUTH ADVOCATE**

**SACRAMENTO ADVOCACY FOR FAMILY EMPOWERMENT (SAFE) PROGRAM**

**EMAIL OR FAX TO:**

Attn: Family And Youth Coordinator/Liaison

Address | 720 Howe Avenue, Suite 108, Sacramento, CA. 95825

Fax | (916) 855-5448 | Phone | (916) 855-5427

[safeprogram@calvoices.org](mailto:safeprogram@calvoices.org)

**CLIENT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Name | | | |  | | | | | | | Date of Referral | | | | |  | | |
| Parent/Caregiver’s Name | | | | | | |  | | | | | | | | | | | |
| Child’s DOB | | |  | | | | | | | | | | SSN |  | | | | |
| Street Address | | |  | | | | | | | | | | | | | | | |
| City, State, Zip | | | | |  | | | | | | | | | | | | | |
| Phone |  | | | | | | | | | Email | |  | | | | | | |
| School | |  | | | | | | | | | | | | | | | | |
| Individual Education Plan (IEP) | | | | | | | | YES | NO | | | | | | | | | |
| Health Insurance | | | | | |  | | | | | | | | | Medi-Cal: | | YES | NO |

**REFERRING PARTY**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring Person/Agency |  | Phone |  |
| System Partners/Others Involved (i.e. CAPS, Probation, Child Welfare, etc.): | | | |
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**SERVICES REQUESTED**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Advocate Type: | Family Advocate | | Youth Advocate | |  |
| Level of Anticipated Involvement (Check One): | | | | | |
| One Time Contact (+/-) | | Occasional/Periodic | | More Intensive | |
| (REQUIRED) Expectations of support from the Family/Youth Advocate  (i.e. Include primary issues, need, and concerns of the family) | | | | | |
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**CLIENT DEMOGRAPHICS**

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| **Please indicate participant’s age group:** | |
| * Child/Youth (0-15) * Transitional Age Youth -TAY (16-25) | |
| **Please indicate participant’s sex** | |
| * Male * Female | * Intersex * Decline to state |
| **Please indicate participant’s sexual orientation:** | |
| * Asexual * Bisexual * Demisexual * Fluid * Gay * Graysexual * Heterosexual/Straight * Lesbian | * Pansexual * Queer * Questioning or unsure * Another sexual orientation: * Decline to answer |
| **Please indicate participant’s gender identity:** | |
| * Male * Female * Intersex * Transgender * Agender * Genderqueer * Genderfluid | * Nonbinary * Two Spirit * Questioning or unsure * Another gender identity: * Decline to answer |
| **Please indicate participant’s ethnicity:** | |
| * Hispanic or Latinx * Non-Hispanic/Non-Latinx * More than one ethnicity | * Another ethnicity: * Unknown * Decline to answer |

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| **Please indicate participant’s primary language:** | |
| * Arabic * Armenian * ASL * Cambodian * Cantonese * English * Farsi * French * Hebrew * Hmong * Ilocano * Italian * Japanese * Korean * Lao | * Mandarin * Mien * Other Chinese Language * Other Non-English Language * Polish * Portuguese * Russian * Samoan * Spanish * Tagalog * Thai * Turkish * Vietnamese * Another language: * Unknown/Not Reported * Decline to answer |
| **Please indicate participant’s race:** | |
| * African American/Black * American Indian or Alaska Native * Asian Indian * Caucasian/White * Chinese * Cambodian * Filipino * Former Soviet * Hawaiian * Hmong * Japanese * Korean | * Laotian * Mexican * Mien * Other * Other Pacific Islander * Samoan * Ukrainian * More than one race * Another Race: * Unknown/Not reported * Decline to answer |
| **Select all that are applicable:** | |
| * Homeless * Current or former foster youth * Lives with a disability | * Family member of someone who has a mental illness * Veteran * None |

**OFFICE USE ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| Assigned Staff |  | Date Assigned |  |

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| --- | --- | --- | --- |
| Specific measurable goal(s) - (Attach Recovery Plan) | | | |
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| Anticipated frequency for peer contact (i.e.1x weekly, 1-3 times monthly) | | |  |
| Length of anticipated service (i.e. for the next 6 months) | |  | |
| Target date for formal review of progress |  | | |