**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

**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 |  |

|  |
| --- |
| 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 |  |