Family & Adolescent PARTNERSHIP

# KIDS NEEDING EXTRA (KNEX)
# Multi-Agency Staffing Team

Date of Referral: _____ School: _____

Youth: _____ DOB: _____ Grade: _____

Parent/Guardian: _____

Contact Information: _____ (address)

_____ (city, state, zip)

_____ **(primary phone)**

_____ (alternate phone or email)

| Community Involvement | |
|---|---|
| **Probation**<br>□ Prior □ Current | **Mind Springs Health**<br>□ Prior □ Current |
| **Senate Bill 94**<br>□ Prior □ Current | **MCDHS**<br>□ Prior □ Current |
| **Truancy Court**<br>□ Prior □ Current | **Other:** |

**Does this youth currently have insurance?**
□ Yes □ No
**If Yes, what type:**
□ Medicaid □ CHP+
□ Private
□ Other _____

**Goal of Staffing:** _____

_____

_____

_____

_____

_____

_____

_____

** Family will also be offered Case Management services upon outreach*

**Referral Source Information**

Name: _____ Phone: _____

Organization/Position: _____ Email: _____

**□ I give my consent to be referred to the Family & Adolescent Partnership (FAP) for a voluntary assessment for services. This includes database documentation of demographics and case progress to meet funding requirements.**
**□ I authorize FAP, the referring agency and/or a Family Navigator (with Hilltop Community Resources or Ariel Clinical Services) to share specific confidential information about myself and/or my minor children for the purpose of providing collaborative services.**

**Guardian (Signature):** _____ **Date:** _____

I understand that these records are protected under Federal and State confidentiality Regulations. Information about services I am receiving cannot be disclosed without my written consent. I understand any communication that is outside this release description cannot be shared without first notifying the party signing this release. I also understand that I may revoke this consent in writing, otherwise it shall continue in effect for one year from the date above.

Please return this **referral form** to the Family & Adolescent Partnership by one of the methods below:

**Email to FAPreferrals@htop.org or Fax** 970-241-1283

**Questions? Concerns? Comments? 970-244-0613 or FAPreferrals@htop.org**

**This is not a referral for funding. For funding, please contact us at the above phone number or email.**