

SCHENECTADY COUNTY UNIVERSAL REFERRAL / INITIAL CONTACT FORM

NAME: _____ **M/F**
LAST ADDRESS: _____
(with zip code) _____
PHONE: _____

TODAY'S DATE: _____
DOB: _____ **AGE:** _____
RACE: _____
ETHNICITY: Hispanic or Non-Hispanic

WHO IS YOUTH LAST RESIDING WITH:

NAME: _____
ADDRESS: _____

RELATIONSHIP: _____
PHONE: _____

REFERRAL/REFERRER INFORMATION:

Name: _____
Phone # of Agency: _____

Agency: _____
Email: _____

HOW CONTACT WAS MADE: Phone In-person Other: _____

REASON FOR HOMELESSNESS: _____

Is this youth currently involved with: DSS/CPS Probation Safe Harbour

Are services being requested from: DSS/CPS Probation Safe Harbour

BACKGROUND HISTORY:

DOES CLIENT HAVE MENTAL HEALTH DIAGNOSES? Yes No

If yes, please list diagnoses: _____

IS CLIENT ON ANY MEDICATION? Yes No

If yes, please list medications: _____

DOES CLIENT HAVE A CRIMINAL HISTORY? Yes No

If yes, please list charges and explain: _____

IS CLIENT A SEX OFFENDER? Yes No

DOES CLIENT HAVE ANY SUBSTANCE ABUSE HISTORY? Yes No

If yes, please list drug(s) of choice and explain: _____

**** If client is not from Schenectady County, please refer client to his/her County of Origin's Department of Social Services where a worker will need to call Safe for placement and will then give the client a shelter letter. Schenectady County DSS On-Call (518) 382-0383****

ACCEPTED INTO SHELTER:

Yes When and how will client arrive at Safe House? _____

No Is client in need of outpatient services? Yes No

(If yes, a staff member will contact the client.)

ANY ADDITIONAL OBJECTIVE COMMENTS/CONCERNS: _____

STAFF SIGNATURE: _____

DATE: _____

SUPERVISOR SIGNATURE: _____

DATE: _____