Youth Acceptance Collaborative
Referral Form

Youth must be under the age of 18

Today's Date _____/_____/_____

YOUTH INFORMATION

Legal Name _____ **Preferred Name** _____

DOB _____ **Phone Number** _____

Currently in foster care Yes ___ No ___ **CSEC History** Yes _____ No ___ **Juvenile Justice History** Yes ____ No _____

Child Welfare Worker: Name/ phone _____

Probation Office: Name/ phone _____

Emergency Contact: Name/Relationship/Phone _____

Allergies _____ **Current Medication** _____

FAMILY/CAREGIVER INFORMATION

Family Member /CaregiverName(s)_____

Phone(s) _____

Relationship to Youth (i.e. birth parent, foster parent, grandparent, etc. _____

_____

REFERRAL INFORMATION

Name of person making the referral _____

Phone _____

Relationship to Youth _____

Reason for Referral:

SERVICES REQUESTED

_____ Youth Advocate Services: Individual SOGIE support services for youth

_____ Family Advocate Services: Individual support services for family members and caregivers to receive support around their child/youth's SOGIE.

May the Youth Acceptance Collaborative contact the youth and/or family directly? YES ___ No___

Does the youth and/or family know they were referred to the YAC for services? YES ___ No___

PLEASE SUBMIT REFERRAL FORMS

- fax referral to 510-727-9405 Attention: BAYC Intake Coordinator
- email referral to stephanief@baycyouth.org

QUESTIONS

Call 510-727-9401 x115
Email: Stephanief@baycyouth.org

REFERRAL APPROVED BY SSA STAFF

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