



OAKLAND COUNTY YOUTH ASSISTANCE PROGRAM REFERRAL FORM

Reason	Area	Staff

PLEASE PRINT IN BLACK INK

Last First Middle

Sex Date of Birth Parent / Guardian Email

Address City Zip Code

Asian Black Caucasian Hispanic Multi-racial

(w)
(h)
(cell)

Mother's Name Address City and Zip Phone

(w)
(h)
(cell)

Father's Name Address City and Zip Phone

(w)
(h)
(cell)

Step-parent or Guardian (living with child) Address City and Zip Phone

Name of School Grade School District

Name of Local Youth Assistance Program

BRIEF DESCRIPTION OF REASON FOR REFERRAL (use additional sheets if necessary)

[Large empty box for description of reason for referral]

●Upon acceptance of services, families will be assessed a \$25 processing fee●

Have other agencies or school services been involved? Yes No
If yes, who?

Is parent aware of referral? Yes No Is youth aware of referral? Yes No
Has parent been informed of processing fee? Yes No

Signature of Referring Person: / Date: _____
(signature required)

Print Full Name of Referring Person: _____

Address: _____ City and Zip Code: _____

Telephone: _____ Agency: _____