Direct Referral ☐ Court Ordered ☐ ID # ______ Appt Date: ______ MDT Date: ______ Re-Staffed MDT: ______ Date: ______	**SILVER STAR RESOURCE CENTER** **REFERRAL FORM** 855 E. Laurel Drive, Building H Salinas, CA 93905 Ph. 831.755.8917 Fax 831.755.8925 **PLEASE COMPLETE ALL SECTIONS OF THIS FORM** Email completed form to ssrc@co.monterey.ca.us	Silver Star Staff Only: Appointment Date: Referral Closed? ☐ Yes Reason referral closed:

Date: ______ To: **Silver Star Resource Center**

Referred by: ______ Agency Name: ______ Title: ______

Tel#: ______ Probation Status: ______ Name of Probation Officer: ______

Minor's Name: ______ DOB: ______ Age: ______ ☐ Male ☐ Female

Place of Birth: ______ Grade Level: ______ Minor's Contact #: ______

School Attending or Last Attended: ______ Minor's email: ______

Special ED/IEP? ☐ Yes ☐ No Date of Last IEP: ______ Minor's Preferred Language: ______

1. Primary Caregiver's Name: ______ Contact #: ______

Address: ______ City: ______ Zip Code ______

Email: ______

Primary Caregiver Spanish Speaking: ☐ Yes ☐ No Primary Caregiver Preferred Language: ______

2. Other/Secondary Caregiver's Name: ______ Contact #: ______

Secondary Caregiver Preferred Language: ______ Email: ______

Address: ______ City: ______ Zip Code: ______

Insurance: ☐ Medi-Cal ☐ Insurance: Specify what type of insurance if known: ______

Were parent(s)/guardian(s) notified of this referral? ☐ Yes ☐ No

Reason for Referral/ (check if applicable):	**YOUTH STRENGTHS:**
☐ School Problems: ☐Expelled ☐Truancy ☐Failing Grades ☐Behavioral **please be specific with school related issues in each area** ☐ Gang involvement: ☐Associates ☐Gang Member: Affiliation: ______ ☐ Family Problems (**describe**): ☐ Substance Abuse: Type: ______ Amount: ______ How Often: ______ ☐ Behavioral Health Concerns (**Complete the additional CBH Referral Form attached** in order for the referral to be processed) ☐ Violence (peers, family) (**describe**): ☐ Other:	☐ Other adult support system ☐ Family Support ☐ Leadership ☐ Pro social beliefs ☐ Positive peers ☐ Attending school ☐ Interest/ talents: ☐ Other:

Recommended Program(s):		
☐ The Parent Project (Parents of Youth Ages 11–18 ONLY) ☐ Strengthening Families (Ages 10–16) (Parent and Youth Attend) ☐ Mentoring (Youth Ages 11–14) ☐ Loving Solutions (Ages 5–10) ☐ Workforce Development Board (Ages 16–21) ☐ DAISY (Substance Abuse) (Youth Ages 13–18) ☐ DAISY (Anger Management) (Youth Ages 13-18) ☐ Behavioral Health (Complete CBH Referral Form Attached if checking this box)	☐ YATV (Youth attending SUHSD) ☐ Restorative Justice Program ☐ Victim Impact Class ☐ School Based (Harden/Carr Lake Middle & Elementary Schools) ☐ Sun Street Centers ☐ Harmony at Home ☐ D.A. / Check Truancy Status ☐ Silver Star Assessment ☐ Other: ***Prior known programs/referrals** Program Name: ______ Date: ______ Completed: ☐ Yes ☐ No	Additional Information for MDT:

SSRC Children's Behavioral Health Supplemental Referral Form

(to be completed by the referring party based on current information)

1. Has the minor/your child requested to be referred to services? ☐Yes ☐ No
2. Does the minor/your child want to participate in therapy services? ☐Yes ☐ No ☐ Unsure
3. Has the minor/your child ever received mental/behavioral health services? ☐Yes ☐ No

   If so, when?: ______________________________

   Where? ☐Private/Community-Based Therapist ☐County/School Counseling Services

   Name of provider: ______________________________

Risk

1. Has the referred minor/your child ever attempted Suicide? ☐Yes ☐ No ☐N/A

   If yes, when? ______________________________

2. Has the referred minor/your child ever been a threat to others (violence)? ☐Yes ☐ No ☐N/A

   If yes, when? ______________________________

3. Is the referred minor/your child using drugs to the point of overdose? ☐Yes ☐ No ☐N/A

   If yes, when? ______________________________

4. Has this minor/your child ever been held on a 5150/5585? ☐Yes ☐ No ☐N/A

   If yes, when was the most recent hospitalization? ______________________________

5. Are the youth's parents/caregivers supportive of this service referral? ☐Yes ☐ No

   Name of parent/caregiver of youth agreeing to this referral: ______________________________

6. Parent/ caregiver or referring party please describe the most significant mental health concern for this youth: