## Re-Entry & Family Services

# REferral FORM

|  |
| --- |
| (Please Print) |
| Email: | Today’s Date: |
| client INFORMATION |
| Last name: | First: | Middle: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Marital status (circle one) |
|  | Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow ❑ |
| Is this your legal name? | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: |
| ❑ Yes | ❑ No |  |  |  / / |  | ❑ M | ❑ F |
| Street address: | Social Security no.: | Home phone no.: |
|  |  | ( ) |
| P.O. box: | City: | State: | ZIP Code: |
|  |  |  |  |
| Last Place Incarcerated: | Most Recent Charges: | Supervision Level & Release Date |
|  |  |  |
| Referred to OAR by (please check one box): | ❑ Dr. |  | ❑ Website | ❑ Self |
| ❑ Family | ❑ Friend | ❑ Probation/Parole | ❑ RE-Entry Council | ❑ Other (Specify) |  |
| Other: |  |
|  |
| client history |
| (Referral should not have any blank fields. Please put N/A when necessary.) |
| Pending Court Hearings: | Probation Start & End Date: | Release Plan Address (if different): | Jail/Prison Security Level: |
|  |   |  |  |
| Supervision/Institutional Adjustment: | ❑Positive  | ❑Negative |  |  |
| OST Risk Level: | Most Risk Level: | Compass Risk & Needs: | Jail Related Disciplinary Actions: |
|  |  |  |  |
|  |
| Please select if you have a history or need any of the following: | ❑ Gang Involvement  | ❑ Housing Needs | ❑ Child support case | ❑ Substance Abuse | ❑ Clothing |
|   | ❑ Mental Health  | ❑ Employment | ❑ Identification  | ❑ Other |  |
| Name/Title of referral source: | Referring Agency: | Work Phone:  | Cell Phone: |
|  |  |  |  |
|  |  |  |  |  |  |
|  |
| To Be completed by staff only |
| The client does ❑ does not ❑ meet the criterion for OAR Re-Entry Services. | Denial Reason:  | Waitlist: | Work phone no.: |
|  |  |  | ( ) |
| Additional Information:  |
|  |  |  |  |  |
|  | Reviewer signature |  | Date |  |