Transition Age Youth Housing Programs
821 Mendocino Avenue
Santa Rosa, CA 95401
T (707) 528-3020
F (707) 528-7699

To: Referring Placement Worker
From: THP Program Director

RE: Intake Process

In order to process your referral of a young adult to one of our Transition Age Youth Housing Programs, there are several documents we need.

The follow is a list of documents and information that needs to be provided to us for evaluation of program appropriateness for your client:

- ☐ Initial and current court reports
- ☐ Discharge Report from past placements
- ☐ Psychological Evaluations *(if applicable)*
- ☐ Psychiatric Medication Summaries *(if applicable)*
- ☐ Most current I.E.P. *(if applicable)*
- ☐ Transitional Independent Living Plan *(TILP)*
- ☐ Referral Form *(included)*
- ☐ Risk Assessment Questionnaire *(included)*
- ☐ Participant Application *(included)*

The following documentation must be provided upon intake:

- ☐ California ID--Please note that clients without a valid ID may be denied program entrance
- ☐ Copy of Birth Certificate
- ☐ Proof of Medical Insurance
- ☐ Foster Care Verification form on County letterhead. Include dates of care and DOB

For youth under 18 years of age:

- ☐ Medical Consent *(included)*
- ☐ Health & Education Passport

Please include the above documents as part of a complete application so that a timely decision can be made.

Sincerely,
THP Program Director

TLC Child & Family Services

Referral Form

Transitional Housing Programs
077-THPP

Date of Referral	Referred by	Phone Number	Program
			☐ THPP ☐ THP+FC ☐ THP+

Youth Information

Name	Birth Date	Age

Gender	Ethnicity	Case Number

Current Address

Foster Parent/Group Home Contact (if applicable)	Phone Number

Other Contact (CASA, Therapist, etc)	Phone Number	Other Contact (CASA, Therapist, etc)	Phone Number

Current School	Project Graduation Date	Employment Status

Currently Active in ILP	ILP Coordinator
☐ Yes ☐ No	

Youth's Strength

Independent Living Goals

Please route referral form to the THP Program Director for review.

Competed referrals will be faxed or mailed to:
TLC Child and Family Services
Attention: Program Director
821 Mendocino Avenue
Santa Rosa, CA 95401
Fax (707) 528-7699

TLC Child & Family Services

Risk Assessment Questionnaire

Transitional Housing Programs
086-THPP

To be completed by the referring party

The following questionnaire is designed to assist in identifying specific issues that may affect the placement of and/or services to be provided to prospective participants. Depending upon the needs of the young adult, additional information may need to be gathered prior to the placement of a young adult in the transitional housing program. The questions on this form should be reviewed by the participant's placement worker prior to admission. If the answer to any of the questions on this form is yes; the intake staff will gather information to determine whether or not the transitional housing program will be able to admit the client and meet his/her needs.

Date:

Name:

Placement Status: CPS ☐ Probation ☐ Mental Health ☐

A. ABUSE/NEGLECT

Does the applicant have a history as a victim of any of the following?

YES	NO	
☐	☐	Physical abuse
☐	☐	Sexual abuse
☐	☐	Abandonment
☐	☐	Emotional abuse
☐	☐	Neglect
☐	☐	Medical neglect
☐	☐	Ritualistic abuse
☐	☐	Exploitation

If the answer to any of the above questions is yes, please describe the type and extent:

Any therapy the applicant has received or requires:

Any special precautions to be taken in the care of the applicant:

Names and relationships of any person he you is to have NO contact with:

B. DELINQUENCY

Does the applicant have a history of any of the following?

YES	NO	
☐	☐	Offenses against people
☐	☐	Offenses against property
☐	☐	Drug or alcohol related offenses
☐	☐	Use of weapons
☐	☐	Arson
☐	☐	Sexual offenses
☐	☐	Truancy
☐	☐	Runaway
☐	☐	Gang activity
☐	☐	Stealing

If the answer to any of the above questions is yes, please describe the type and frequency of the activity:

The approximate date of the last involvement in the activity:

Gang affiliation, if any:

Is the youth currently on probation? ☐ Yes ☐ No

If yes, what are the conditions that may impact placement?

What were the charges?

C. Mental/developmental status

Do any of the following apply to the applicant?

YES	NO	
☐	☐	Mental disorder (DSM, current revision, diagnosis)
☐	☐	Developmental disability
☐	☐	Deficits in self help skills
☐	☐	Requires psychotropic medications
☐	☐	Special education pupil, certified, Seriously Emotionally Disturbed

If the answer to any of the above questions is yes, please provide the pertinent information.

Is the applicant eligible for and/or receiving services through a Regional Center? ☐ YES ☐ NO

If yes, please give the provider name and summary of services:

Does the applicant have a DSM diagnosis? If yes, please list any past or current treatment: ☐ YES ☐ NO

Has the applicant ever been an inpatient of a mental health facility or developmental center? ☐ YES ☐ NO

If yes, please provide the dates, reasons, and location of hospitalizations:

D. HEALTH STATUS

Applicant's primary physician's name and phone:

Applicant's therapist's name and phone:

Does the applicant use any prescription medications? ☐ YES ☐ NO
If yes, please list prescription:

Does the applicant have any of the following?

YES	NO	
☐	☐	Asthma
☐	☐	Epilepsy
☐	☐	Allergies
☐	☐	Diabetes
☐	☐	Eating disorder
☐	☐	Visual impairment
☐	☐	Hearing impairment
☐	☐	Infectious disease
☐	☐	Special diet
☐	☐	Pregnancy
☐	☐	Chronic medical conditions
☐	☐	Are you experiencing any pain
☐	☐	Physical limitations

If the answer to any of the above is yes, please describe the type and severity of the condition:

The treatment the applicant is receiving for the condition:

Any limitations due to the condition:

Any special services required due to the condition:

E. ALCOHOL/DRUG USE

Does the applicant have a history of drug or alcohol use?

YES ☐ NO ☐

If yes, please describe the types of drugs, alcohol or inhalants used:

Frequency of use:

Are there any current concerns regarding the use of drugs or alcohol?

YES ☐ NO ☐

If the answer to any of the above is yes, please describe.

F. BEHAVIORS

Does the applicant have a history of any of the following?

YES	NO	
☐	☐	1. Non-compliance
☐	☐	2. Resistance to authority
☐	☐	3. Temper tantrums
☐	☐	4. Verbal abusiveness
☐	☐	5. Self-harm or suicide attempts
☐	☐	6. Restlessness or hyperactivity
☐	☐	7. Depression or withdrawal
☐	☐	8. Anxiety
☐	☐	9. Lying
☐	☐	10. Inappropriate sexual behavior
☐	☐	11. Medication non-compliance
☐	☐	12. Refusal of medical treatment

If the answer to any of the above is yes, please describe the behavior(s):

The frequency and duration of the behavior(s):

The approximate date of the last occurrence of the behavior(s):

Anything that seems to trigger the behavior(s):

Strategies to deal with the behavior(s):

Name of professional filling out this form

Date

Signature of professional filling out this form

TLC Child & Family Services

Consent for Medical Treatment & Psychiatric/Psychological Assessments & Treatment

094-TC

As the parent, authorized representative, or legal guardian, I hereby give consent to TLC Child and Family Services (hereafter called 'TLC') to provide all medical or dental care prescribed by a duly licensed physician (M.D.) or Dentist (D.D.S.) for: _____.
Name of Dependent

I also give consent to TLC to exchange information with, and have my child (named above) treated by psychologist and psychiatrists who consult with TLC.

This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

_____ _____
Parent, Authorized Representative, Guardian Signature Date

_____
Printed Name of above signature

_____ _____
Address County

_____ _____ _____
Name of Insurance Company Policy Number Expiration Date