Direct Referral ☐

SILVER STAR RESOURCE CENTER
REFERRAL FORM

ID#: _____

Appt Date_____

MDT Date_____

855 E. Laurel Drive, Bldg. H
Salinas, CA 93905
(831) 796-1350 FAX (831) 755-8925

Date:
Referred by:
Agency: _____
Probation Status_____

To: Silver Star Resource Center
Tel. #:
Title:
Name of Probation Officer:

Child's Name: _____ DOB: _____ Age_____Sex: ___ Ethnicity: ___
Place of birth _____ SSN: _____ Tel.
Address: _____
City, State, Zip: _____
Parent's Name: ___Cell #: _____Work# _____
School: _____Grade: ____ IEP?
Child Spanish Speaking? ☐ YES ☐ NO Parent Spanish Speaking? ☐ YES ☐ NO Medi-cal # _____

Reason for referral (check if applicable):

☐School problems___Not on truancy probation at this time.___
☐ Truancy ☐ Behavioral problems ☐ Failing grades

☐ Gang involvement (Associating with gang members, wearing gang clothing, possessing gang paraphernalia)
_____

☐ Unstable home environment putting youth at risk of gang involvement_____
☐ History of out-of-home placement or hospitalization during past year_____
☐ Family Problems _____
☐ Substance abuse causing functional impairment in living skills Substances used:_____
☐ Present or past criminal activity: Parent or Child (On formal/informal probation or incited criminal activity)
☐ Signs of depression or anxiety ☐ Suicide attempt Date: _____
☐ Domestic Violence _____ Hospitalized ☐ YES ☐ NO
☐ Violent behavior _____ ☐ History of Dept. of Social Services involvement
☐ Parents with any of the above problems ☐ Other: _____

Is the Youth receiving services from any other county or city agencies? ☐ YES If Yes, what services?
_____

Is youth or parent interested in obtaining additional information about the Boys & Girls Club? ☐ YES ☐ NO
Past Boys and Girls Club Member? ☐ YES ☐ NO

Recommended programs:
☐ OET ☐ MCOE
☐ Mentoring ☐ Second Chance
☐ DAISY ☐ Beh Health
☐ DA Truancy Abatement
☐ Strengthening Families(ages 10-14)
☐ Life Skills ☐ Boys & Girls Club
☐ Grief Busters
☐ CYO
☐ 7 Challenges
☐ YATV
☐ Sunrise House
☐ Silver Star Assessment
☐ Other _____
☐ Court ordered program_____

For Silver Star Staff only:
Appointment Date_____

Referral Closed? ☐ YES
(No participation)

Reason referral closed:
_____

Program Start Date_____

Program End Date_____

Number sessions _____
Completed successfully?
☐ YES ☐ NO

Additional Information for MDT:
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Revised 2/18/10