Safe Inc.
OF SCHENECTADY
"Where Hope Shapes the Future"

Referral for Life Skills Program

Referral is for individuals who are homeless, in Schenectady County, between the ages of 18-35.

NAME:_____ **M / F** **TODAY'S DATE:** _____

LAST ADDRESS: _____ **DOB:** _____ **AGE:** _____

(WITH ZIP CODE) _____ **RACE:** _____

PHONE: _____ **ETHNICITY:** Hispanic or Non-Hispanic
(please circle one)

WHO IS/WAS YOUTH LAST RESIDING WITH:

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____ **PHONE:** _____

WHO IS MAKING THE REFERRAL:

Name: _____ **Agency:** _____

Phone # of Agency: _____ **Email:** _____

REASON FOR HOMELESSNESS: _____

_____

Is this youth currently involved with: □**DSS** □ **Probation/Parole** □**Safe Harbour**

Name of worker & contact number: _____ _____ _____

BACKGROUND HISTORY:

DOES THE CLIENT HAVE A MENTAL HEALTH DIAGNOSES? □Yes □No
If yes, please list diagnoses:_____

IS CLIENT ON ANY MEDICATION? □Yes □No
If yes, please list medications:_____

DOES CLIENT HAVE A CRIMINAL HISTORY? □Yes □No
If yes, please list charges and explain: _____

IS CLIENT A SEX OFFENDER? □Yes □No

DOES CLIENT HAVE ANY SUBSTANCE ABUSE HISTORY? □Yes □No
If yes, please list drug(s) of choice and explain:_____

Please fax to 518.357.8127 Attn: Robin Romines or email to romines.robin@safeincofschenectady.org