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

Referral For 3-day respite

Referral is between the ages of 14-15. Client is able to stay for 72 hours with a discharge plan to be picked up by legal guardian before 4pm. Stay is voluntary and no medication management is provided.

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/CPS** □ **Probation** □**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:____

Discharge plan:
Client will be picked up in 72 hours by:____

Please fax to 518.357.8127 Attn: Shelter Manager or email to decarmine.athena@safeincofschenectady.org