Juvenile Referrals to Repay, Inc.

NC DPS JUVENILE JUSTICE/JCPC REFERRAL FORM (Please print or type)

Date of Referral:	(MM – DD – YYYY)					NC-JOIN ID:					
Program:			County:								
Client Name:	DO		B:		SSN: xxx-xx-		X-		Gender:	M 🗌 F 🗌	
Hispanic/Latino □	Race: Sch			ool/Grade:							
Legal Guardian:		Phone:									
Legal Guardian's rela											
Physical Address:				City:			Z	Zip:			
Mailing Address:			City:				Z	<u>Z</u> ip:			
If child is receiving services elsewhere, please include PCP with Repay, Inc. added and please include signature page											ge <u>*</u>
Is there Juvenile Ju	stice Inv	olvement?				Yes 🗌 No 🗌					
Is participation in this	program	court ordered?				Yes No No					
Is participation in this program a part of a diversion plan/contract? Yes \[\] No \[\]											
Court Counselor:				Phone:				Emai	il:		
Client Risk Score/Lev	ient Risk Score/Level:				Client Needs Score/Level:						
Current Legal Status	Current Legal Status: Problem Behaviors \ Risk Indicators:										
NA/No Juvenile Just	ice INI	DIVIDUAL		INDIVIDUA	L (co	ntinued)	1	sc	CHOC	L (continue	ıd)
Involvement				☐ Substance Use (alcohol					/∟ (Conuniue	u)	
		Bullying Behavior			ınce l	Jse (alc	-				
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Additional Client Information:								
Does the client speak English? Yes 🗌 I	Vo 🗌 V	What is the primary language spoken in the household?						
Does the client have an Exceptional Designation (EC or IEP)? Yes \(\subseteq \text{No } \subseteq \)								
List any current medical problems:								
List all current medications:								
Does client have private medical insurance	e? Yes	□ No □						
Does client have Medicaid/ Health Choice	? Yes	□ No □						
If "No," has parent/guardian applied for Me	edicaid or	Health Choice? Yes No No						
Enter the number of problems the client has experienced over the previous 12 months:								
Number of Runaways		Unknown						
Number of Short-Term Suspensions		Unknown						
Number of Long-Term Suspensions		☐ Unknown						
Number of Expulsions		☐ Unknown						
Additional Comments:								
Name of Person Making Referral:								
Title:								
Phone:								
Email:								
Describe the reason you're referring this client to this Program:								
Date Referral Received by Program:	-	- (MM – DD – YYYY)						

If child is receiving services elsewhere, please include PCP with Repay, Inc. added and please include signature page

Please fax the completed form to Repay, Inc. at 828-439-2340.