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:		DOB:		SSN:	xxx-xx-	Gender:	M ☐ F ☐
Hispanic/Latino ☐	Race:		School/Grade:				
Legal Guardian:				Phone:			
Legal Guardian's relationship to client:							
Physical Address:		City:		Zip:			
Mailing Address:		City:		Zip:			

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

Is there Juvenile Justice Involvement?			Yes ☐ No ☐		
Is participation in this program court ordered?			Yes ☐ No ☐		
Is participation in this program a part of a diversion plan/contract?			Yes ☐ No ☐		
Court Counselor:		Phone:		Email:	
Client Risk Score/Level:		Client Needs Score/Level:			

Current Legal Status:

- ☐ NA/No Juvenile Justice Involvement
- ☐ Court Counselor Consultation
- ☐ Diversion Plan/Contract
- ☐ Petition Filed
- ☐ Deferred Prosecution
- ☐ Adjudicated Undisciplined Disposition Pending
- ☐ Adjudicated Delinquent Disposition Pending
- ☐ Protective Supervision
- ☐ Probation
- ☐ Commitment
- ☐ Post Release Supervision
- ☐ Continuation Services

Problem Behaviors \ Risk Indicators:

INDIVIDUAL

- ☐ Bullying Behavior
- ☐ Negative Labeling/Bullied
- ☐ Crime/Delinquency (unreported & reported)
- ☐ Fighting/Assault/ Aggressive Behavior
- ☐ Fire Setting
- ☐ Impulsive/Risk Taking
- ☐ Mental Health Issues/Depression/ Anxiety/Temper Tantrums
- ☐ Poor Social Skills/Anti-social
- ☐ Run Away from Home
- ☐ Self-Mutilation
- ☐ Sexually Active
- ☐ Sexual Offense
- ☐ Sexual/Physical/Mental Abuse/ Victimization/ Trauma

INDIVIDUAL (continued)

- ☐ Substance Use (alcohol or drugs)
- ☐ Suicide Attempts
- ☐ Suicidal Ideation/Threats

FAMILY

- ☐ Excessive Dependence on Parents
- ☐ Family Conflict
- ☐ Lack of Discipline by Parent or Child is Ungovernable
- ☐ Siblings or Parent/Guardian on Probation or Incarcerated
- ☐ Substance Use in Home

SCHOOL

- ☐ Academic Failure/Behind Grade Level for Age
- ☐ Behavior Problems: Disruptive in Class/ Referrals to Office/ Suspensions

SCHOOL (continued)

- ☐ Truancy/Skipping School

PEER

- ☐ Gang Associate or Member; or Gang Involvement
- ☐ Negative Peer Associations/ Association with Aggressive Peers
- ☐ Typically Associates with Negative Older Persons

COMMUNITY

- ☐ Availability or Perceived Access to Drugs
- ☐ Disadvantaged/ Disorganized/ Impoverished Neighborhood
- ☐ Feeling Unsafe in Home Neighborhood
- ☐ High Crime Rate in Home Neighborhood

Additional Client Information:			
Does the client speak English?	Yes ☐ No ☐	What is the primary language spoken in the household?	
Does the client have an Exceptional Designation (EC or IEP)?	Yes ☐ No ☐		
List any current medical problems:			
List all current medications:			
Does client have private medical insurance?	Yes ☐ No ☐		
Does client have Medicaid/ Health Choice?	Yes ☐ No ☐		
If "No," has parent/guardian applied for Medicaid or Health Choice?	Yes ☐ 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)

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