Sally Kate Winters Family Services

Shelter Program

REFERRAL FORM

To make a referral or request for placement complete form, fax or email to shelter staff

Phone: 662-494-4867 Fax: 662.494.0870
Mailing Address: P.O. Box 1233/ 801 North Division St., West Point, MS 39773

Section 1

Date:_____ County: _____

Social Worker and contact info _____

Section 2 – Youth Section

Name: _____ Age _____ ◻ Male ◻ Female ◻ Other Race _____

Please provide information on: reason for being in custody, how long in custody, prior placements and reason for leaving placement.

_____

_____

_____

Section 3
Behavior Problems:

_____

_____

_____

Long-term Plans for youth: _____

Mental Health Diagnosis: _____

Is the youth currently taking any medications to address mental health issues/concerns: : ◻ Yes ◻ No

Name of medication(s) or change in medication: _____

List any current or past medical issues (asthma, allergies, Infections, bed wetting, STD, etc._____

_____

Completed Psychological Evaluation? ◻ Yes ◻ No If yes, please Fax

Current grade level:_____ Educational disabilities: _____

Plans for education? _____

Does the youth a history of aggression: : ☐ Yes ☐ No peers and/or adults:

_____

_____

Does the youth have a history of drug use: ☐ Yes ☐ No If yes, what drugs:_____

Does the youth have a history of alcohol use: ☐ Yes ☐ No Date of last incident: _____

Has the youth ever attempted to hurt themselves? : ☐ Yes ☐ No If yes, when and how _____

Has youth had any homicidal behaviors? ☐ Yes ☐ No If yes, when and how _____

Has youth had runaway history? If yes, when _____

Has the youth have or had any of the following COVID-19 symptoms?

Exposed to COVID_ 19	Fatigue or muscle/body aches	Nausea
Fever or chills	headache	Vomiting
Cough	loss of taste or smell	Diarrhea
Shortness of breath	sore throat	

REQUIRED PAPERWORK UPON INTAKE

RSA- Residential Service Application	Court Order	Insurance Card
CFA- Comprehensive Family Assessment	Social Security Card, Birth Certificate	Copy/ Medical, Dental, Vision
FSP- Family Service Plan	Social Summary	Immunization or TB skin test if applicable

FOR OFFICE USE- select number and initial

Accepted/Denied

☐

1. Higher level care needed
2. Safety concern/Behavior
3. Did not call back or send info
4. Found Another Placement
5. Conflict with current Residents
6. Short staffed
7. Accepted but did not come
8. Requested documents not received
9. No beds available
10. Other _____

Staff Initial: _____

For Internal Use ONLY:

☐ **Logged**