Division of Youth Services

Intensive In-Home Services Referral Form

Youth Name:		Youth DOB:	

Check all that apply:	Risk Factors	Protective Factors
	☐ Defiant/oppositional ☐ Delinquent ☐ Family conflict ☐ FINS history ☐ Fire-setting ☐ Gang association ☐ Homicidal ideation ☐ Physical aggression ☐ Problem sexual behavior ☐ Property destruction ☐ Self-harm ☐ Substance use ☐ Suicidal ideation ☐ Trauma history ☐ Truancy ☐ Verbal aggression	☐ Acknowledges risk-factors ☐ Completed problem sexual behavior treatment ☐ Completed substance use treatment ☐ Positive adult influences ☐ Pro-social activities ☐ Positive peers ☐ Positive school performance ☐ Resilient personality ☐ Strong family connection ☐ Supportive caregiver(s) ☐ Utilizes community resources (case management, counseling, etc.)

Is the youth 17 or younger?		☐ YES	☐ NO
Are services court ordered?		☐ YES	☐ NO
Is the family actively seeking help?		☐ YES	☐ NO
Is the family willing to commit to program requirements?		☐ YES	☐ NO
Are there safety concerns that would prevent staff entering the home?		☐ YES	☐ NO
Have alternative community supports been attempted?		☐ YES	☐ NO
SAVRY Score (if SAVRY has been completed):	☐ LOW	☐ MODERATE	☐ HIGH

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Intensive In-Home Services Referral Form

ARKANSAS DEPARTMENT OF HUMAN SERVICES

REFERRING TO (for DYS completion only): ☐ ST. FRANCIS ☐ YOUTH ADVOCATE PROGRAM ☐ YOUTH VILLAGES

Youth Name:		**Youth DOB:**	
Gender:		**Race:**	
Social Security:		**Medicaid ID**	
Address:			
County of residence:		**Current FINS:**	☐ YES ☐ NO
Education Track:	☐ **High School**	**Credits:**	of 22
	☐ **GED**	**Status:**	
	Current Educational Institution:		
Guardian Name: **Guardian Phone:**	_____ _____	**Preferred Language:**	
JPO (if applicable): **JPO Phone:** **JPO Email:**	_____ _____ _____	**DHS Worker (if applicable):** **DHS Worker Phone:** **DHS Email:**	_____ _____ _____
Case manager (if applicable): **Case manager phone:** **Case manager email:**	_____ _____ _____	**Therapist (if applicable):** **Therapist phone:** **Therapist email:**	_____ _____ _____

Reasons for referral:

Criminal History	**Past Charges:**
	Pending Charges/County:
	Is youth currently on probation? ☐ YES ☐ NO
Health and Medical	**Diagnoses:**

	Treatment History (acute placements, residential settings, etc.):
	Medications:
	Additional Medical Information:
Family Involvement	**Does the family participate in treatment?** ☐ YES ☐ NO
	Who lives in the home? **NAME** **DOB** **RELATIONSHIP** _____
	Comments:

History of Abuse & Trauma	☐ Substance	☐ Physical	☐ Sexual
	Comments:		

Additional Information:

Submitting Party:		Date Completed:	
Organization:			

_____ _____

Submitting Party Signature Date

PLEASE COPY DYSInHome@dhs.arkansas.gov ON ALL CORRESPONDENCE REGARDING INTENSIVE IN-HOME SERVICES