

EXTENDED FAMILY PROGRAMS

Referral Form for Day Treatment – Middle and Secondary

10565 Lincoln Highway Everett, PA 15537 * Ph: (814) 623-2220 * Fax: (814) 623-1715

Blair DTX _____ Everett DTX _____ Fulton DTX _____

Child's Name: _____ Age: _____ M/F Referral date: _____

Parent/Guardian Name: _____ Phone: _____

Address: _____ PA Secure # _____

Home School: _____ Grade: _____ DOB: _____ SS#: _____

Referring Agency: _____ Contact Person: _____

Address: _____ Phone: _____

This referral is for the traditional school day (8:00 am to 3:00 pm)

***** Students must attend at least 45 school days and maintain a consistent positive behavior before staff will recommend the return to the home school district*** A review of the student's goals will be completed every 30 school days.**

Circle the estimated length of stay

45 school days 90 school days Remainder of the year

Other agencies involved with the child include:

- _____ Juvenile Probation _____ Children & Youth _____ Drug & Alcohol
- _____ CASSP _____ Foster Child (Foster Provider) _____
- _____ MH/MR _____ Outpatient Counseling: (agency) _____
- _____ Other: _____ _____ SAP Team

Copies of the following information (if applicable) MUST be submitted before consideration for enrollment:

- _____ IEP and NOREP (**reflecting** change in placement) _____ Permanent Record Card
- _____ Current Discipline Referrals _____ Latest Report Card
- _____ CYS Family Service Plan _____ Court Orders, Custody Papers, etc.
- _____ Psychiatric-Psychological information _____ Most recent Eval/ER
- _____ Most recent physical & immunization records _____ Functional Behavior Assessment

Has this child ever been in placement before? _____ YES _____ NO If yes, please describe.
Where, when, discharge date, disposition: _____

***Does this child have a current IEP? _____ YES _____ NO

***Date IEP completed: _____ IQ: _____ (required)

***If the student is 14 or older, does he/she have a transition plan incorporated with the IEP?
_____ YES _____ NO **If yes, indicate the responsible party for this service**

Home School/Contact: _____ IU-08/Contact: _____

Child's Name: _____

*****Reasons for referral/presenting problem: (You must check at least one and supporting documentation must accompany the referral).**

As defined under 24 P.S. 19-1901-C(5), alternative education for disruptive youth programs may admit students that demonstrate any or all of the following conditions: (Please check all that apply)

- _____ Disregard for authority, persistent violation of school policy and rules
- _____ Display or use of controlled substance on school property
- _____ Violent or threatening behavior on school property, under 18 PA C.S. 912
- _____ Commission of a criminal act on school property or during school-affiliated activities
- _____ Misconduct that would merit suspension or expulsion
- _____ Habitual truancy

***** School District goals: (Please indicate expected measurements/outcomes of progress for student to return to the district. Example: 80% of the time or 8 out of 10 times):**

***** List previous behavior interventions utilized by referring agency:**

As the referral source, I have informed the family about the reasons for referral, estimated length of stay, and the expectations for return to the home school.

YES NO

As the parent/guardian, I understand the reasons for the referral, the expectations of the referral source, and the length of stay for my child.

Signature of Parent/Guardian

Date

As the referring agency, I understand that I will seek and/or arrange funding for the above child's enrollment with Extended Family Programs.

Referring Source/Payment Authorization

Date

It should be noted that each child will have an Individual Service Plan completed by EFA Staff within the first 30 days. Updates to that plan are completed on a regular basis. Parents, as well as other agencies involved with the child, will be invited to the ISP meeting. The EFA teacher will address any educational needs at that time.

All information marked with * MUST be completed before the referral will be accepted for review. PLEASE FAX REFERRAL FORMS TO THE OFFICE AT (814) 623-1715**

