HENDRICKS COUNTY YOUTH ASSISTANCE PROGRAM
Resource Services for Youth, ages 3-17 years, and their Families

AVON REFERRAL FORM

REFERRAL SOURCE

□ School Representative

□ Service Provider

□ Law Enforcement

□ Parent

□ Other _____

YOUTH INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Male Female Grade: _____

Youth Lives with: Mother Father Grandparent Legal Guardian Foster Parents

Other: _____

FAMILY INFORMATION

Name of Parent or Guardian: _____

Email: _____

Cell Phone: _____

REASON FOR REFERRAL Please check all indicators that apply.

□ Youth is involved with DCS

□ Youth may become involved with Juvenile Justice

□ Youth demonstrates social problems

□ Youth demonstrates emotional problems

□ Youth demonstrates behavioral problems

□ Youth has poor or declining grades: below grade level below ability cannot focus/concentrate

□ Youth is exposed to drugs/alcohol in the home

□ Youth is exposed to domestic violence in the home

□ Youth has experienced trauma (physical, sexual, verbal/psychological, neglect) in the home

□ Youth has experienced bullying in school, at home, on social media, in public

□ Youth has recently lost a parent, grandparent, family member, friend, pet

□ Youth has a parent/guardian currently incarcerated/previously incarcerated

□ Youth is an immigrant or refugee with adjustment concerns

Please provide any recommendations for services through the Plainfield Youth Assistance Program that you believe would benefit this youth and family.

Additional Comments:

THANK YOU FOR YOUR REFERAL

Please email to:

brandi@hendricksyouthassistance.org