Connecticut Department of Children and Families
COMMUNITY-BASED LIFE SKILLS PROGRAM (CBLS) REFERRAL FORM
DCF-3001
12/13/2016 (New)

NOTE BEFORE COMPLETING THIS REFERRAL FORM: Youth in PASS, TFC, SWETP, TLAP or Group Homes are not eligible for CBLS. Those programs are required to provide a Life Skills Education Program to the youth residing in their program. Target population for CBLS is DCF-involved youth, age 14 to 21, residing in an out-of-home placement. Exclusionary criteria include: active psychotic behavior, violent/assaultive behavior or active substance abuse.

CONTACT INFORMATION

Youth's LAST Name: | Youth's FIRST Name: | Date of Referral:
DOB: | Age: | Race: Please Select One | Ethnicity: Please Select One
Citizenship status: Victim of Trafficking | Birth Gender: Please select one | Current Gender: Please select one
Prefers to be called / Nickname: | Link | Link CASE ID
Address: | City: | State: | Zip:
Phone #: | Cell Phone #: | E-mail:
DCF Office: Please Select DCF Office
DCF Worker: | Phone #: | E-mail:
DCF Supervisor: | Phone #: | E-mail:
CBLS Liaison: | Phone #: | E-mail:

LEGAL STATUS

☐ Committed Abuse/Neglect/Uncared for ☐ 18 + ☐ Dually Committed ☐ Voluntary Services
Type of Placement: ☐ DCF Foster Home ☐ Relative Foster Home ☐ Therapeutic Foster Home ☐ Residential Facility
☐ Other:

EDUCATION

School Name: | School Contact Person:
Address: | City: | State: | Zip:
Phone #: | Cell Phone #: | E-mail:
Current Educational Concerns, if any: | Long term Education Goals:
Grade: | Grade Level: | College:
☐ After School Activities, if any: | Times
Afterschool Activity Schedule: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
☐ College Prep/accelerated ☐ General Studies ☐ GED ☐ Alternative Learning Program ☐ Vocational/Technical
☐ Special Ed?: If Yes, please explain:
☐ Current Educational Concerns / Special needs, if any:
☐ Is Youth currently employed?: ☐ Yes ☐ No *(Please ensure that the Youth's work schedule does not conflict with the CBLS Schedule)*
If Yes, Where?: | Work Schedule:

YOUTH INFORMATION

Youth's Interests: | DSM V Diagnosis:
Youth's medical conditions / allergies (to food, medications or insects: | Please list Medications, if applicable:

Any Special, Relevant Considerations for Educator's to know?:

Provide a brief assessment of the Youth's ability and willingness to participate in this program and in a group setting:

Does the youth have a substance abuse history? ☐ Yes ☐ No If yes, is the youth ☐ Sober ☐ in Treatment ☐ Actively using
Provide any information regarding obstacles or issues that the youth is currently dealing with, e.g., living situation, behavioral problems or issues, grief, sexual/gender identity, handicap, illness, etc.

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Provider (please indicate the name/agency provider if you have a preference)			
Recommended Provider Agency Name			
Address:	City:	State:	Zip:
Case Manager Name:	Phone #:	E-mail:	
Youth may participate in group activities ☐ Yes ☐ No			
Has Youth Completed a LIST Assessment?: ☐ Yes ☐ No	If Yes, Please provide the assessment date:		
If Yes, Please attach the most current LIST Assessment			
Who completed assessment?:	Phone #:	E-mail:	
Has youth previously participated in Life Skills? ☐ Yes ☐ No	If Yes, Which?:	Date:	

SERVICES AND PROVIDERS (if applicable)			
Foster Parent/Placement Contact Name:			
Address:	City:	State:	Zip:
Phone #:	Cell Phone #:	E-mail:	
CHAP/CHEER Case Management Agency Name (if any):			
Case Manager Name:	Phone #:	E-mail:	
Juvenile Justice Services (FREE, Probation etc.), Agency Name (if any):			
Case Manager Name:	Phone #:	E-mail:	
Is youth participating in a Work to Learn program? ☐ Yes ☐ No	If Yes, Name of Program?		
Where (Location)?:	When (Days/Hours)?:		
TFC Home?: ☐ Yes ☐ No	If Yes, please provide TFC Home Name:		
Case Manager Name:	Phone #:	E-mail:	
Other contact information that you feel may be helpful in coordinating services:			
Additional Comments, Statements, or Anything else you would like to add or like us to know?:			