**Department of Social Services**

**Juvenile Justice Reinvestment Initiative**

**ADDITIONAL SERVICES REFERRAL FORM**

**Agency Completing the Form:** Choose an item.

**COMPLETED BY AGENCY STAFF**

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| --- |
| Client Name:       |
| STARS ID:       |
| Agency Providing Current Services: Choose an item. |
| Current Service(s):       Additional Services Needed:       |
| Reasons unable to address needs in FFT/MRT/ART:       |
| **FFT ONLY:** Case staffed with FFT Clinical Supervisor/Consultant and approved for additional services): Yes: [ ]  No: [ ]  N/A: [ ]  If no, please explain:       |
| Agency Providing Additional Services:       |
| Anticipated Start Date of Services:       |
| Anticipated End Date of Services:       |
| Funding Source for Additional Services:       |
| Will JJRI service continue or be placed on hold:       |
| Additional Information:       |

**\*Please remember to also staff the case with the referral source and make them aware of the status.**

**This form does not serve as funding approval. Please follow existing protocol to request funding for any additional services approved.**

**COMPLETED BY DBH PROGRAM SPECIALIST**:

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| Date Form Received:  |
| Date Approved:  |

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Program Specialist Signature Date