**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