CAPITAL YOUTH MENTORING PROGRAM

A SERVICE OF SHILOH COMMUNITY DEVELOPMENT CORPORATION
416 BELLEVUE AVENUE-SUITE# 407
TRENTON, NEW JERSEY 08618

MENTEE REFERRAL FORM

THIS DOCUMENT MUST BE COMPLETED AND FAXED TO
Jeneya Richardson 609 392 0295
Office: 609 392 0034 Ext# 316
Cell Phone: 609 325 1756

YOUTH INFORMATION

Youth Full Name:
Date of Birth:
Age:
Gender:
Race:
NJSpirit ID:
Personal ID:
School Name:
Grade:
Youth's Phone Number:
Youth's Email:

PARENT INFORMATION

Parent's Full Name:
Address:
City:
State:
Zip Code:
Home Phone:
Mobile Phone:
Email Address:

DCPP INFORMATION

DCPP Local Office:
DCPP Case Manager:
DCPP Case Manager Phone:
DCPP Case Manger Email:
DCPP Supervisor:
DCPP Supervisor Phone:
DCPP Supervisor Email:

CMO-CAPITAL COUNTY CHILDREN'S COLLABORATIVE INFORMATION

CMO Case Manager:
CMO Case Manager Phone:
CMO Case Manager Email:
CMO Supervisor:
CMO Supervisor Phone:
CMO Supervisor Email:

RESIDENTIAL OUT OF HOME PLACEMENT

Out of Home Placement? (YES_____) (NO_____)
Name of Facility:
Address of Facility:
Phone:
Type of Facility: (Resource Home____) (Group Home____) (Residential Treatment___)
Contact Person/Caretaker
Contact Person Phone:
Contact Person Email:

JUVENILE JUSTICE PROBATION AND PAROLE

Youth is on:
-Probation____
-Parole_____
Probation Officer Name:
Probation Officer Phone:
Probation Officer Email:
Parole Officer Name:
Parole Officer Phone:
Parole Officer Email:

Explain the reason youth has been adjudicated:
What are the terms of Probation/Parole?
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SERVICE HISTORY

Is youth currently receiving mentoring services? (Yes___) (No___)
Mentoring Provider Name:
Mentoring Provider Phone:
Mentoring Provider Email:

Is youth currently receiving counseling or therapy? (Yes___) (No___)
Name of Provider/Agency:
Phone Number of Provider/Agency:
Email Address of Provider/Agency:

Is youth currently engaged in any other services or activities? (Yes__) (No___)
Name of Provider/Agency:
Phone Number of Provider/Agency:
Email Address of Provider/Agency:

REASON FOR REFERRAL

This youth is being referred for assistance in the following area: (Check all that apply)			
Academic Issues ( )	Behavioral Issues ( )	Delinquency ( )	Job Skills ( )
Self Esteem ( )	Needs role Model ( )	Social Skills ( )	Life Skills ( )
Peer Relationships ( )	Family Issues ( )	Special Needs ( )	Attitude ( )
Other, Specify:			
On a scale of 1-10 (10 being the highest) rate youth's level of:			
Social Skills ( )		Communication Skills ( )	
Self-Esteem ( )		Attitude about ( )	
Family Support ( )		Understanding Job Readiness Skills ( )	
Academic Performance ( )		Peer Relationships ( )	

Please provide details of youth's challenges and case manager's expectation of how the mentor will support the youth?

PERSONAL

Please list youth unique abilities, skills interest:
Doe the youth have any behavioral or cognitive issues that may require a mentor with special skills?
List any mental/behavioral health issues and treatment providers:
List any medical issues and treatment providers:
List any medication taken on a daily basis for any reason (medical or psychotropic)
List food allergies:
List safety concerns:
List special cultural issues:
List any challenges involving parent/caretaker:

Please provide any additional information, factors or issues that may support or hinder our efforts to engage this youth and family.

REFERRED BY

Name of Person Completing this Referral:
Relationship to Youth:
Your Agency Name:
Your Phone #:
Your Email Address:
Date Form Completed:
xPLEASE SIGN:

If you are submitting this form electronically please note that you are providing a legal signature.