SCOTT COUNTY COMMUNITY CORRECTIONS

JUVENILE ALTERNATIVE FACILITY ● 17681 VALLEY VIEW DRIVE ● JORDAN, MN 55352-9382
EMERGENCY 911 ● (952) 496-8950 ● Fax (952) 496-8955

Date: **Youth name:** **DOB:** **Age:**

Referring Agent: **County**:

Office Phone # **Cell/pager #** **Email:**

Social Services: ☐ **Court Services/Community Corrections:** ☐ **Other:** ☐

Program requested: (if other please specify) Select Program
(Please attach court order, voluntary placement, or chips petition authorizing placement with referral)
Agent emergency contact number(s) if youth placed on voluntary placement:

Does youth have a current Case Plan? Yes ☐ No ☐ if so, please attach.

Does youth have a current YLS/CMI 2.0? Yes ☐ No ☐ if so, please attach.

Does youth have a current IEP or 504 Plan? Yes ☐ No ☐ if so, please attach.

Last School / School District youth was enrolled in? **Grade level**:

Risk Assessment: Vulnerable ☐ Sexual ☐ Assaultive ☐ Other concerns ☐
Additional Info:

Has youth taken the MAYSI-2 mental health assessment within the last 180 days?
Yes ☐ No ☐

If yes, please indicate risk areas identified by the assessment.
☐ Alcohol/drug use ☐ Angry/irritable ☐ Depressed/anxious ☐ Somatic complaints
☐ Suicide ideation ☐ Thought disturbance (boys) ☐ Traumatic experiences
☐ No risk areas were identified

If no, please indicate reason youth is exempt from screening.
☐ Under care of mental health professional ☐ Already screened within the past 180 days
☐ Diagnostic assessment within past 180 days ☐ Parent/ Guardian prevented screening
☐ Unable to locate child/released from custody ☐ Case closed within 30 days

☐ Other:

Objectives agent is requesting (be specific to include restitution, community service hours, apology letters, court dates, and appointments etc.)

Please list any program restrictions while in placement:

Scheduled appointments or court dates during placement:
Please list pertinent disabilities (e.g. physical, visual, auditory, developmental, or intellectual):

Medication: Yes ☐ No ☐ if yes please list:
(Please send a minimum 7 day supply of medication(s) in appropriately labeled bottles)
Pharmacy: **Phone:**

Primary Physician/Clinic:
Phone:

Medical Assistance #:
Private insurance:
Group ID: **Policy number:**

No insurance ☐

Other professionals involved with youth (names, addresses, and phone numbers.

Parent information (names, addresses, and phone numbers.)

Parent Email Address's:

Approved visitor/phone contacts (names, relationship, and phone numbers.)

Please provide a list of advocates the youth may utilize while in placement if applicable (names, relationship, and phone numbers.)

30 Day evaluation referral (Please complete if requesting psychological evaluation)

Reason for referral (**Try to be as detailed as possible so that the assessment can be appropriately focused)**
a) What situation(s) led to the evaluation?
b) What are the **specific** questions that need to be answered by the assessment?
c) Are there **specific** concerns about mental health functioning, dangerousness to self or others, intellectual ability, or neurological functioning?

Has the child been placed/hospitalized in the past? Yes ☐ No ☐ Where, when?
Request records:

Who are the caretakers that can be called for an interview for purposes of collaborative information:

Has youth completed prior evaluation(s)? Yes ☐ No ☐ If yes, please attach.

Is the evaluation court ordered? Yes ☐ No ☐ if yes, when is his next court date?

Request all related treatment/mental health records, relevant police reports, social history/probation assessments, and other data than can help provide insight into the child's current placement situation.