 **Only use arrow down/up keys to navigate. Do not use tab key.**

**MDHHS-6093, Independent Living Plus Program Referral**

Michigan Department of Health and Human Services (MDHHS)

Children’s Services Administration (CSA)

(New 7-24)

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**section 1 – general information**

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| MiSACWIS Person Identification (ID) |

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| --- | --- |
| Youth’s Legal Name (last, first) | Youth’s Preferred Name, if applicable |

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| --- | --- | --- |
| Date of Birth | Age | Youth Sex Assigned at Birth[ ]  Female [ ]  Male |

|  |  |
| --- | --- |
| Gender Identity | Gender Pronouns |

|  |  |
| --- | --- |
| LGBTQIA+ Resources Needed?[ ]  Yes [ ]  No | Religion |

|  |
| --- |
| Other Social or Cultural Information and/or Needed Resources |

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| --- | --- |
| Language(s) spoken | Indian Child Welfare Act (ICWA) Case?[ ]  Yes [ ]  No |

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| --- | --- | --- | --- |
| Current Address | City | State | Zip Code |

|  |  |
| --- | --- |
| Youth Email Address | Youth Phone Number |

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| --- |
| Length of Stay at Current Placement |

|  |
| --- |
| Current Placement Type[ ]  Secure Residential [ ]  Non-Secure Residential [ ]  Hospitalization [ ]  Shelter[ ]  Independent Living [ ]  Independent Living Plus [ ]  Foster Home[ ]  Other (specify)  |

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| Reason(s) for entry into care |

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| --- |
| What is youth’s trauma history? (For example, prior physical abuse, sexual abuse, etc.) |

**section 2 – referral source**

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| --- | --- |
| Name of Referring Worker | Title |

|  |  |
| --- | --- |
| Phone Number | Email Address |

|  |  |
| --- | --- |
| Referring Agency | Date of Request |

**section 3 - education**

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| --- | --- |
| Current School | Grade Level |

|  |  |
| --- | --- |
| School Phone Number | Name of Contact at School |

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| --- |
| Currently Attending?[ ]  Yes [ ]  No [ ]  Individualized Education Program (IEP)/504 Plan |

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| School/Education Comments or Concerns? |

**section 4 – daily living skills**

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What life skills or responsibilities does the youth currently have? (For example: does chores, keeps track of own schedule, can navigate public bus system independently, etc.)

List below and put ‘x’ in column that best represents skill level for each skill/responsibility.

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| --- | --- |
| Skill/Responsibility | Level of skill/responsibility |
| Not At All Proficient | Slightly Proficient | Occasionally Proficient | Normally Proficient | Extremely Proficient |
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| What life skills or responsibilities does the youth need to work on and cultivate? (For example:getting up on time, maintaining boundaries with family, etc.) |

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| List the youth’s top three strengths. |

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| --- |
| List the youth’s top three needs. |

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| Has youth demonstrated capability to follow rules? (For example, is respectful to staff, abides by curfew, etc.)[ ]  Yes [ ]  No (if No, explain) |

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| --- |
| Has youth demonstrated capability to effectively handle emergency situations? (For example, knows when to call 911, uses critical thinking when gets on wrong bus, etc.)[ ]  Yes [ ]  No (if No, explain) |

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| Has youth demonstrated capability to be unsupervised in the home?[ ]  Yes [ ]  No (if No, explain) |

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| --- |
| Has youth demonstrated capability to be unsupervised in the community?[ ]  Yes [ ]  No (if No, explain) |

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| Any additional needs/comments? |

**section 5 – youth supports**

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Who are supportive people in youth’s life? (For example: foster parent, adult sibling, etc.)

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| --- | --- | --- |
| Name | Relationship to Youth | Contact Information |
|  |  | Phone Number Email Address  |
|  |  | Phone Number Email Address  |
|  |  | Phone Number Email Address  |

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| What strategies might be effective for a mentor or staff member working with this youth and why? |

**section 6 – employment**

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| Is youth currently employed?[ ]  Yes [ ]  No |

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| If ‘No’, is youth currently searching and applying for jobs?[ ]  Yes [ ]  No |

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| Name of Employer |

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| --- | --- |
| Length of employment | Number of hours worked per week. |

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| Any additional concerns/comments related to employment? |

**section 7 – health history**

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| Is youth receiving any mental/physical health treatment? (Includes routine treatment likeallergies/asthma, diabetes, mental health counseling, etc.) |

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| --- | --- | --- |
| Exam Type | Most Recent Exam Date | Treating Provider Name and Contact Information |
| Physical |  |  |
| Dental |  |  |
| Other (vision, specialist, etc.) |  |  |

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| Mental or physical health concerns? If yes, describe. |

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| --- | --- | --- |
| Medication Name and Dose | Diagnosis | Prescriber’s Name, Phone Number, and Email Address |
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| --- |
| Is youth compliant with medication & in agreement with current treatment plan(s)?[ ]  Yes [ ]  No |

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| --- |
| If no, provide additional information. |

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| --- |
| Does youth have current issues with substance abuse?[ ]  Yes [ ]  No [ ]  Unsure |

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| --- |
| If Yes, is youth receiving treatment?[ ]  Yes [ ]  No [ ]  Unsure |

|  |
| --- |
| If Yes, is youth actively participating in treatment?[ ]  Yes [ ]  No [ ]  Unsure |

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| Any other relevant health information/concerns not covered above? |

**section 8 – safety**

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| Has youth ever been charged with (check all that apply)[ ]  Gun possession [ ]  Sexual offense [ ]  Theft [ ]  Arson [ ]  Assault (physical or sexual)[ ]  Illegal Substances (specify)      [ ]  Other (specify)       |

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| Convictions/probations?[ ]  Yes (if yes, explain) [ ]  No [ ]  Non-applicable (N/A) |

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| Information that should be considered as mitigating circumstance(s)?[ ]  Yes (if yes, explain) [ ]  No [ ]  Non-applicable (N/A) |

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| Youth vulnerability concerns (For example: PPO, history of suicidality/self-harm, etc.)?[ ]  Yes (if yes, explain) [ ]  No [ ]  Non-applicable (N/A) |

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| Anyone not allowed contact with youth?[ ]  Yes (if yes, provide names) [ ]  No |

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| Any triggers to behavior issues/violence (to self or others) for youth?[ ]  Yes (if yes, describe) [ ]  No |

**section 9 – reason/rationale for referral**

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| Explain why independent living plus is the most appropriate placement for this youth |

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| Additional comments (attach page if needed) |

**Supportive Documents to include with application**

IEP/504 Plan, Psychological Evaluations, Latest Court Order, Initial Service Plan (ISP), Parent Agency Treatment Plan, Safety Plan (if applicable)

Optional:

Updated Service Plans (USPs), Medical Passport, Reference letter(s) of support

**(Do not type beyond this point)**

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**End of form**