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| Service Requested: **VOLUNTEER MENTORING** | | | | | | | | | | | | | | | | | Date of Referral: \_ \_ / \_ \_ / \_ \_ \_ \_ | | | | |
| Referral Source Name: | | | | Relationship to Applicant: | | | | | | | | | | | | | | Referral Source Phone: | | | |
| Name: | | | | DOB: | | | | M  F  T | | | | | | Primary Language: | | | | | | Last 4 SSN (DDS ONLY): | |
| Physical Address of Person: | | | | | | | | | | City/Town: | | | | | | | | | State: | | Zip: |
| Current Living Situation | | Home  Relative | Friends  Homeless | | | Foster Care  Group Care | | | | Shelter/Assessment  Detention/Secure (DYS) | | | | | | Jail/Lock-up  Psych Hospital | | | Medical Hospital  Unknown | | Current diagnosis: |
| Primary Phone: (     )      -  Primary Email: | | | | | Alternate: (     )      - | | | | | | | | | | | Race:  Multi- Racial White (non-Hispanic)  Black (non-Hispanic)  Hispanic/Latino  Asian/Pacific Islander  Native American | | | | | |
| Ethnicity | African  African American  Asian Indian/Pakistani  Brazilian | | Cambodian  Cape Verdean  Central American  Chinese | | | | Dominican  Cuban  Eastern Europe  European | | | | Haitian  Jamaican  Japanese  Laotian | | | | Mexican  Middle Eastern  Portuguese  Puerto Rican | | South American  Uruguayan  Vietnamese  West Indian | | | Other (describe) | Translator needed?  Yes  No |
| Primary Insurance: | | | | | | | | | | | Policy #: | | | | | | | | | | |
| Secondary Insurance: | | | | | | | | | | | Policy #: | | | | | | | | | | |
| Number of units authorized: | | | | | | | | | | | | | If DMH, has PDI been completed?  Yes  No | | | | | | | | |
| Person financially responsible for this applicant:  Self  Parent/Guardian  Other: | | | | | | | | | | | | | | | | | | | | | |
| Case Worker Name: | | | | | | | | | Phone Number: Phone: (     )      - | | | | | | | | | | | | |
| Person to contact for appointment:       Relationship to Client: | | | | | | | | | | | | | | | | | | | Phone: (     )      - | | |
| **If Person under 18:** Caregiver 1 Name:  Caregiver’s Primary Language:  Will they be involved in treatment  Yes  No | | | | | | | | | | | | **If Person under 18:** Caregiver 2 Name:  Caregiver’s Primary Language:  Will they be involved in treatment  Yes  No | | | | | | | | | |
| Address:  Same  Other: | | | | | | | | | | | | Address:  Same  Other: | | | | | | | | | |
| Primary Phone: (     )      -     , Email  Alternate: (     )      - | | | | | | | | | | | | Primary Phone: (     )      -      , Email  Alternate: (     )      - | | | | | | | | | |
| Does caregiver have legal custody?  Yes  No | | | | | | | | | | | | If no, Guardian Name:       Relationship:  Phone Number: | | | | | | | | | |
| Gender Preference ­­­­­­­­­­for LUK Staff:Female Male No Preference **Request Specific Staff:**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Available Most Days and Times  Preferred Time, Day & Location:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| ***Brief Description of Needs Requiring Service*:**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Where Do the Needs Impact Functioning?***  Home  School  Community  Other     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Client’s Strengths (Social, Interpersonal, Personal care, Behavioral, Academic, Arts/Sports/Recreational etc.):***      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Current Reactions/Behaviors/Functioning (Check all that Apply):***  Aggression  Anxiety  Attachment Difficulties  Attention/ Concentration  Conduct Problems  Depression  Dissociation  Impulsivity  Oppositional Behaviors  Physical Disabilities  Problems with Emotional Regulation  Reactive to Trauma Reminders  Self-Harm  Somatization/Physical Complaints  Substance Use  Severe Allergies  Other     \_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| ***In order to help link the person to the best service we need to ask a few additional questions.***  Do you know of any really scary or upsetting thing that happened to the (your) child or (your) the child’s family in their lifetime?  YES  NO  Is Person the victim or family member of a DUI?  YES  NO  Is the person a military member, veteran, or family member?  YES  NOIf yes, please describe who:        ***Are there any factors that will impact the person’s ability to attend face-to-face appointments in one of LUK's facilities?***  No  Transportation  Child Care  Disability  Financial Hardship  Other      \_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| Other Provider: | | | | | | | | Role: | | | | | | | | | | | Phone: (     )      - | | |
| Other Provider: | | | | | | | | Role: | | | | | | | | | | | Phone: (     )      - | | |
| ***CALL:*** Toll-Free: 800-579-0000 Direct Line: 978-829-2222  ***All referral materials can be sent to:*** Email: [referrals@luk.org](mailto:referrals@luk.org) Fax: 978-829-2250 | | | | | | | | | | | | | | | | | | | | | |