



# Referral & Pre-placement SCREENING ASSESSMENT

**Referral Information:** Date of Referral: \_\_\_\_\_ Referral Completed by: \_\_\_\_\_

**Service Partner Information**

Name (first/middle/last):		Age:	Birth Date:
Permanent Address (Street Address & Mailing Address):			
Last Known Place of Residence:			
Nickname/ Alias:		Cultural Heritage/Ethnicity:	
Race:		Tribal Affiliation:	
Language of Service Partner:		Language of Service Partner's Family:	

**Placement Authority:** \_\_\_\_\_ Ramsey County \_\_\_\_\_ Hennepin County \_\_\_\_\_ Other (\_\_\_\_\_)

**Type of Referral:** \_\_\_\_\_ Probation \_\_\_\_\_ Mental Health \_\_\_\_\_ Child Protection \_\_\_\_\_ Other

**Legal Status (Check ALL That apply):** \_\_\_\_\_ Court-ordered Placement \_\_\_\_\_ CHIPS \_\_\_\_\_ Extended Juvenile Jurisdiction (EJJ) \_\_\_\_\_ Status Offender \_\_\_\_\_ Non-status Offender \_\_\_\_\_ Termination of Parents Rights \_\_\_\_\_ Voluntary Placement

Comments:

**Referral Source Contact Information:**

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

\_\_\_\_\_ Social Worker \_\_\_\_\_ Probation Officer \_\_\_\_\_ Child Protection \_\_\_\_\_ Other (\_\_\_\_\_)

Mailing Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

**Insurance Information:** Medical Assistance: \_\_\_\_\_ Yes \_\_\_\_\_ No Health Plan: \_\_\_\_\_

MA/ Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Information and Sources Utilized to Determine Appropriateness of Referral: (Check ALL that Apply)**

\_\_\_\_\_ Placement Plan \_\_\_\_\_ Psychological Assessment \_\_\_\_\_ Psychiatric Assessment \_\_\_\_\_ IEP

\_\_\_\_\_ Discharge Summary \_\_\_\_\_ Previous Placement Reports \_\_\_\_\_ In person Screening Session

\_\_\_\_\_ Health Records \_\_\_\_\_ Referral Sources Notes \_\_\_\_\_ Other (\_\_\_\_\_)

Comments:

**DI Representatives Involved in Determining Appropriateness of the referral: (please list name & title)**

(NOTE: DI Executive Director & Program Director must be consulted with on all referrals.)

Aretta-Rie Johnson, Executive Director  
 Vicky McMillan, Program Director



Pre-Placement Assessment			
Determination Criteria	Yes	No	Comments (if applicable)
The D.I.V.I.N.E. Intervention Program and services is able to meet the Service Partner needs? Cultural Emotional Educational Mental Health Physical Needs			
Can D.I.V.I.N.E. Intervention program and services meet the needs of the Service Partner?			
Is Service Partner a sex offender?			
Is the Service Partner in need of any Abuse Prevention Plan? i.e. substance; sexual; safety (suicide); aggressive; relationship; bullying;			
Is Service Partner likely to engage in sexual abusive behavior?			
Is the Service Partner a danger to the Service Partners self or others?			
Does the Service Partner need a chemical health assessment?			
<b>Shelter Services or Group Home Services desired?</b>			

**Assessment Summary:**

**Assessment Determination:**

**The D.I.V.I.N.E. Intervention can meet the needs of the Service Partner?** \_\_\_\_\_ Yes \_\_\_\_\_ No

**Referral Accepted** \_\_\_\_\_ Yes \_\_\_\_\_ No **If YES....** Projected Intake Date:

**If NO....** Reasons referral was declined:

**If NO.....** Date Referral Source was informed:

**Signatures:**

**Staff Person:** \_\_\_\_\_ **Date:**

**Program Director:** \_\_\_\_\_ **Date:**