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Description automatically generated

**VOA Youth Residential Services Referral Form**

**Please return this form with the following documentation:**

* **Releases of information**
  + **County social worker, children’s mental health case manager and/or probation officer**
* **Relevant legal documentation**
  + **Custody order (if applicable)**
  + **Court order (if applicable)**
* **Most recent Diagnostic Assessment (within the last 6 months required)**
* **Psychological and/or Neuropsychological Evaluation (most recent if more than one)**
* **Discharge Summaries from previous placements (or completed releases of information to request records)**
* **Progress Reports from current placements**
* **Individual Education Plan and IEP evaluation (if applicable)**
* **Chemical Health Assessment/SUD Assessment with recommendations for treatment (if applicable and/or recommended based on previous/recent psychological assessment/DA/etc.)**
* **CASII (Level 6 consideration requires a CASII completed in last 30 days)**
* **Copies of insurance cards**
  + **If youth has only MA or a prepaid medical assistance plan (PMAP), county involvement is required for placement consideration (Rule 5 funding).**

**IMPORTANT: If appropriate documentation is not provided, review and determination will be delayed.**

**Programs (Please indicate which program(s) you are referring to:**

**Avanti** (Level 5 mental health residential treatment for youth assigned female at birth – ages 12-17)

**Haven** (Level 6 mental health residential treatment for youth assigned male or female at birth – ages 11-17)

* Needs a level 6 CASII from last 30 days to indicate need for locked/secure setting.
* If there is a recommendation for chemical health/dual diagnosis residential treatment, Haven **cannot** offer placement until those recommendations are fulfilled.

**\*\*Please note, the Bar None Omegon program is currently on pause for re-evaluation of services. This pause is anticipated to last into early 2026. Please watch for updates from VOA-MN Youth Residential Services Division.**

**Please submit completed referral form and documentation to:**

Sara Ellis – Youth Residential Services Referral Coordinator

Phone: 763-252-4541

Fax: 888-965-5125

Email: [sara.ellis@voamn.org](mailto:sara.ellis@voamn.org)

**Resident Face Sheet/Referral Form**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** |  | |  |  | | |  |
| **Client Information** | | | | | | | |
| **First name:** | **Middle name:** | | | | **Last name:** | | |
| **Date of birth:** | **Age:** | | **Sex:** | **Preferred pronouns:** | | **Preferred name:** | |
| **Address:** | | | | **SSN:** | | |  |
| **City:** | | | **State:** | **Zip code:** | | |  |
| **Referral source:** | | | | **Place of birth:** | | |  |
| **Child's current location (home, hospital, shelter etc.):** | | |  | **Languages spoken/written:** | | |  |
| **Identifying characteristics (hair/eye color/tattoos etc.):** | | | | | | |  |
| **Race/Cultural Heritage/Native American Tribal Affiliation/Religious or spiritual affiliation:** | | | | | | | |
| **Mother's Name:** | | | **DOB:** | **Phone:** | | | **Contact in an emergency?** |
| **Address:** | | | | **Email:** | | | Yes  No |
| **Father's Name:** | | | **DOB:** | **Phone:** | | | **Contact in an emergency?** |
| **Address:** | | | | **Email:** | | | Yes  No |
| **Other Guardian's Name (Specify Relationship):** | | | **DOB:** | **Phone:** | | | **Contact in an emergency?** |
| **Address:** | | | | **Email:** | | | Yes  No |
| **Is the child adopted?  Yes  No** | **At what age?** | | | | | | |
| **Legal Custody:  Mother  Father  Joint  Other (specify):** | | | | **Physical Custody:  Mother  Father  Joint  Other (specify):** | | | |
| **I have provided a copy of custody paperwork (if applicable).       (initials)** | | | | **Is this a court ordered placement?  Yes  No \*\*If yes, please include court order.** | | | |
| **Is anyone restricted from contact with the child?  Yes  No** | | | **Name:** | | | | **Relation:** |
| **Collateral Contacts** | | | | | | | |
| **Social Worker Name:** | | | | **County:** | | | **Contact in an emergency?** |
| **Address:** | | | | **Phone:** | | | Yes  No |
| **Email:** | | | | **Fax:** | | |  |
| **Probation Officer Name:** | | | | **County:** | | | **Contact in an emergency?** |
| **Address:** | | | | **Phone:** | | | Yes  No |
| **Email:** | | | | **Fax:** | | |  |
| **Children's Mental Health Case Manager:** | | | | **County:** | | | **Contact in an emergency?** |
| **Address:** | | | | **Phone:** | | | Yes  No |
| **Email:** | | | | **Fax:** | | |  |
| **Insurance Information** | | | | | | | |
| **Primary Health Insurance:** |  | |  | **Subscriber name:** | | |  |
| **Policy or ID#** | | **Group:** | | **Phone:** | | |  |
| **Secondary Health Insurance:** |  | |  | **Subscriber name:** | | |  |
| **Policy or ID#** | | **Group:** | | **Phone:** | | |  |
| **Financially Responsible Party (parent/guardian/county etc.):** | | | | **MA#:** | | | |
|  |  | | **Office Use Only Below** | | | |  |
| Unit/Program: |  | | Admission Date/Time: | | | |  |
| Clinician/Case Manager: |  | | Discharge Date: | | | |  |
| Diagnosis at Intake: |  | |  |  | | |  |
|  |  | |  |  | | |  |

*Revised 3/08/19, 8/6/19, 10/23/19, 11/26/19, 3/18/20, 9/2020, 5/2024, 10/2024, 1/2025*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Clinical Information** | | | | | | | | | | |
| **Presenting Problems (what has happened to prompt the search for treatment right now):** | |  | | | | | | | | |
| **Which treatment track are you seeking?**  Level 5 non-secure Mental Health RTC  Level 6 secure Mental Health RTC | | | | | | | | | | |
| **Is this client currently experiencing hallucinations/delusions?** | | | | | | | Yes  No | | | |
| **Is this client a danger to self?** | |  | | |  | | Yes  No | | | |
| **Is this client a danger to others?** | |  | | |  | | Yes  No | | | |
| **Is this client at risk of running away from treatment?** | | | | |  | | Yes  No | | | |
| **Does this client have a history of physically assaulting anyone?** | | | | |  | | Yes  No | | | |
| **Does this client have a history of property destruction** | | | | |  | | Yes  No | | | |
| **Does this client have a history of perpetrating sexual abuse?** | | | | |  | | Yes  No | | | |
| **Does this client have a history of eating disorder behaviors?** | | | | |  | | Yes  No **\*If yes, please indicate/describe below.** | | | |
| Restricting  Purging  Other (please specify): | | | | | | | | | **\*Please include ED assessment if completed.** | |
| **If you answered "yes" to any of the above questions, please provide details in the appropriate boxes.** | | | | | | | | | | |
| **Client's strengths and assets:** | | | | | | | | | | |
| **Goals of treatment/discharge goal:** | | | | | | | | | | |
| **County Case Plan Goals (if applicable):** | | | | | | | | | | |
| **Current MH Professional/Therapist:** | | | | | | | **Phone:** | | | |
| **Address:** | | | | | | | **Fax:** | | | |
| **Current Psychiatrist:** | | | | | | | **Phone:** | | | |
| **Address:** | | | | | | | **Fax:** | | | |
| **Date and location of most recent psychological/neurological testing:** | | | | | | | | | | |
| **Treatment History** | | | | | | | | | | |
| **Type of Setting:** | | **Provider Name:** | | | | | **Estimated dates of service:** | | | |
| **outpatient  inpatient** | |  | | |  | |  | | |  |
| **hospital  day treatment** | |  | | |  | |  | | |  |
| **Type of Setting:** | | **Provider Name:** | | | | | **Estimated dates of service:** | | | |
| **outpatient  inpatient** | |  | | |  | |  | | |  |
| **hospital  day treatment** | |  | | |  | |  | | |  |
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| **hospital  day treatment** | |  | | |  | |  | | |  |
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| **hospital  day treatment** | |  | | |  | |  | | |  |
| **Type of Setting:** | | **Provider Name:** | | | | | **Estimated dates of service:** | | | |
| **outpatient  inpatient** | |  | | |  | |  | | |  |
| **hospital  day treatment** | |  | | |  | |  | | |  |
| **Medications** | | | | | | | | | | |
| **Current medications:** |  | | | | | | **Are any given by injection?** | | | Yes  No |
| **Prescribing doctor:** |  | | | | | | **Phone:** | | | |
| **Address:** |  | | | | | | **Fax:** | | |  |
| **Medical/Health History** | | | | | | | | | | |
| **Has the client had a concussion or TBI?** | | Yes\*  No | | | **\*If yes, date:** | | | | | |
| **Has the client ever had a seizure?**  Yes  No | | **On seizure meds?**  Yes  No | | | | | **Date of last EEG:** | | |  |
| **Does the client have Diabetes?**  Yes  No  Type 1  Type 2 | | **On diabetes meds?**  Yes  No | | | | | **Medication name:** | | |  |
| **Has the client broken a bone in the last month?** | | Yes  No | | |  | |  | | |  |
| **Does the client currently have braces on teeth?** | | Yes  No | | |  | |  | | |  |
| **Has the client ever had a positive Mantoux (Tuberculosis) test?** | | Yes\*  No \****If yes, a chest x-ray is required before admission*** | | | | | | | | |
| **Does the client have any food, animal, or drug allergies?** | | Yes  No **Do they have an epi pen?**  Yes  No | | | | | | | | |
| **\*\*List allergies/reactions:** | | | | | | | | | |  |
| **Any special dietary requirements?** | | Yes\*  No **\*If yes, please explain:** | | | | | | | | |
| **Has the client ever had asthma?** | | Yes\*  No | | | **\*If yes, last time they needed an inhaler:** | | | | |  |
| **Any serious, chronic, or communicable diseases?** | | Yes\*  No **\*If yes, please explain:** | | | | | | | | |
| **Any possibility the youth may be pregnant?** | | Yes\*  No **\*If yes, how far along is the pregnancy:** | | | | | | | | |
| **Any cardiac issues?**  Yes\*  No | | **\*If yes, please explain:**  **Date of last EKG:** | | | | | | | | |
| **Does the client have mobility issues?**  Yes\*  No \***If yes, please explain:** | | | | | | | | | | |
| **Primary Care Physician/Clinic:** | | | | | | | **Phone:** | | | |
| **Address:** | | | | | | | **Fax:** | | | |
| **Dentist/Dental Clinic:** | | | | | | | **Phone:** | | | |
| **Address:** | | | | | | | **Fax:** | | | |
| **Last Physical:** | | | **Last Eye Exam:** | | | | | **Last Dental:** | | |
| **Are there any pending or ongoing medical appointments?**  Yes  No | | | | | **Please explain:** | | | | | |
| **Educational Information** | | | | | | | | | | |
| **Last school attended:** | | | | | | | **Current Grade:** | | | |
| **Address:** | | | | | | | **School contact person:** | | | |
| **Home School District:** | | | | | | | **IQ:** | | | |
| **Individualized Education Plan (IEP)/504 Plan?** | | Yes\*  No **\*If yes, please attach a copy and IEP evaluation for our records** | | | | | | | | |
| **Legal Information** | | | | | | | | | | |
| **Is the client court ordered to attend treatment?** | | Yes\*  No | | | | **\*If yes, please attach a copy of court order.** | | | | |
| **Is the client an adjudicated delinquent?** | | Yes\*\*  No | | | | | | | | |
| **Does the client have assault charges?** | | Yes\*\*  No | | | | | | | | |
| **\*\*Please briefly describe all legal charges or pending charges:** | | | | | | | | | | |
| **Motivation** | | | | | | | | | | |
| **Does the client believe they have a problem with drugs and/or alcohol?** | | Yes  No  NA | | | | |  | | |  |
| **Have they had a Rule 25/Comprehensive/SUD (Chemical Dependency) evaluation?** | | Yes  No  NA | | | | |  | | |  |
| **Does the client want help getting sober?** | | Yes  No  NA | | | | |  | | |  |
| **Does the client know someone is looking into long term treatment for them?** | | Yes  No | | | | |  | | | |
| **Does the client know the program length of stay is between 4-9 months? (varies by program)** | | Yes  No | | | | |  | | | |
| **Is the family/guardian willing to participate in 4 hours of family therapy a month?** | | Yes  No | | | | | **Who will be participating in Family Therapy?** | | | |
| **If referring for Haven, does the family/guardian know the program is a locked/secure setting?** | | Yes  No | | | | |  | | | |
| **Anything else we should know?** | |  | | | | | | | | |
| **Name of person filling out application:** | | | | **Date:** | | | **Signature:** | | | |
| **For Guardians: On behalf of VOA, we would like to place your child in the most appropriate program. Therefore, we would like your permission to share information between all sites and will determine the most appropriate program for your child/youth based on the information provided.**  **Do you agree for information to be shared between VOA’s residential programs?**  Yes  No | | | | | | | | | | |
| **Legal Guardian’s Name:** | | | | **Date:** | | | **Signature:** | | | |