Volunteers of America MN & WI - Youth Residential Services Division
Avanti – Bar None Residential Services

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

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: ☐ outpatient ☐ inpatient ☐ hospital ☐ day treatment	Provider Name:	Estimated dates of service:
Type of Setting: ☐ outpatient ☐ inpatient ☐ hospital ☐ day treatment	Provider Name:	Estimated dates of service:
Type of Setting: ☐ outpatient ☐ inpatient ☐ hospital ☐ day treatment	Provider Name:	Estimated dates of service:
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Type of Setting: ☐ outpatient ☐ inpatient ☐ hospital ☐ day treatment	Provider Name:	Estimated dates of service:

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:**