EXTENDED FAMILY PROGRAMS

Day Treatment Referral Form – Elementary, Middle and Secondary

Po Box 620, Bedford PA 15522 * Ph: (814) 623-1770 * Fax: (814) 623-1715

Blair County_____ **Bedford County _____**

Child's Name: _____ Age: _____ M/F Referral Date:_____

Parent/Guardian Name: _____ Phone: _____

Address: _____ PA Secure #_____

Home School: _____ Grade: _____ DOB: _____ SS#: _____

Referring Agency: _____Contact Person: _____

Address: _____Phone: _____

School Contact E-mail: _____

This referral is for the traditional school day (8:00 am to 3:00 pm)

*** Students must attend **at least 45 school days** and consistently meet daily goals before staff will recommend the return to the home school district*** A review of the student's goals will be completed every **30 school days.**

Circle the estimated length of stay

45 school days 90 school days Remainder of the year

Other agencies involved with the child include:

_____Juvenile Probation ____Children & Youth _____ Drug & Alcohol
_____CASSP ____ Foster Child (Foster Provider) _____
_____MH/MR ____ Outpatient Counseling: (agency) _____
_____ Other: _____ ____ SAP Team

*****Copies of the following information (if applicable) MUST be submitted before consideration for enrollment:**

_____ IEP and NOREP (**reflecting change in placement**) _____ Permanent Record Card
_____ Current Discipline Referrals _____ Latest Report Card
_____ CYS Family Service Plan _____ Court Orders, Custody Papers, etc.
_____ Psychiatric-Psychological information _____ Most recent Eval/ER
_____ Physical & Immunization records (most recent) _____ Functional Behavior Assessment

Has this child ever been in placement before? _____YES _____NO If yes, please describe.
Where, when, discharge date, disposition: _____

***Does this child have a current IEP? _____ YES _____ NO
***Date IEP completed: _____

***If the student is 14 or older, does he/she have a transition plan incorporated with the IEP?
_____YES _____NO **If yes, indicate the responsible party for this service**

Home School/Contact: _____ IU-08/Contact: _____

Child's Name: _____

***Reasons for referral/presenting problem: **(Please explain reason for referral and supply any supporting documentation)**

Extended Family Programs is a Day Treatment serving youth (students K-12)

Districts reason for referral:

_____

_____

_____

_____

_____

_____

*** School District goals: **(Please indicate expected measurements/outcomes of progress for student to return to the district. Example: 80% of the time or 8 out of 10 times):**

_____

_____

_____

*** List previous interventions utilized by referring agency:

_____

_____

As the referral source, I have informed the family about the reasons for referral, estimated length of stay, and the expectations for return to the home school.

YES NO

As the parent/guardian, I understand the reasons for the referral, the expectations of the referral source, and the length of stay for my child.

_____

Signature of Parent/Guardian Date

As the referring agency, I understand that I will seek and/or arrange funding for the above child's enrollment with Extended Family Programs.

_____

Referring Source/Payment Authorization Date

It should be noted that each child will have an **I**ndividual **S**ervice **P**lan completed by EFP Staff within the first 30 days. Updates to that plan are completed on a regular basis. Parents, as well as other agencies involved with the child, will be invited to the ISP meeting. The IU-08 teacher will address any educational needs while the student is enrolled at EFP.

All information marked with * MUST be completed before the referral will be accepted for review.**

PLEASE FAX ALL REFERRAL FORMS TO OUR ADMINISTRATION OFFICE AT (814) 623-1715

REV: 09/24