AWOL ALL WALKS OF LIFE, INC.

P.O. Box 15846, Savannah, Georgia 31416 Θ Phone: 912.303.4987Θ Fax: 912.525-3160 Θ Web: www.awolinc.org

SOCIAL SERVICE REFERRAL FORM

Youth Name: ____ Date of Birth: _________ Age: __________

Male: ___________ Female: _____________ Parent Name:____

Referring Agency: (Example: School, Youth Serving agency, DFACS, Youth shelter, School counselor, ect.)

____

Case Worker: ____ Phone: ______________________________

Email: ____________________________________ ________ Fax: ____

Has the youth ever been referred to the juvenile court system? Yes_____ No _____

If yes, is the youth currently on probation? Yes_____ No _____

What types of problems are being experienced by the youth? Check all that apply.

- Poor academic performance
- Poor behavior at school
- Violence at school or within community
- Asocial behavior at home or within community
- Truancy
- None, just looking for good program for youth

Which of the services listed below do you feel the youth is most in need of at this time?

- Group level mentoring
- Arts and Technology education (something interesting to do)
- Positive relationships with adults and peers
- Conflict Resolution training
- Other:_____________________

Briefly explain the primary reason for your referral and how you feel this youth could benefit from the AWOL program?

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Are funds available from your agency to support youth's participation in AWOL programs? ____Yes_____No

If so, who should be contacted concerning payment of program fees? ______________________________________

AWOL STAFF USE ONLY

Initial Contact Date: ___________________ Result of Contact: ____________________

Method of Contact: __________________ Follow Up Mail Sent: _________________