When complete, please send to:
Mentoring@trinity-ec.com

Mentoring Referral Form

Client Information

Referral Date:

First Name: Middle Initial: Last Name:

Birthdate: Gender: Age:

Where is the Child Placed/Living? Home Home of Relative Foster Care Other:

Parent/Guardian Name: Relationship:

Address:

Phone: Email:

Reason For Referral *(check all that apply)*: Academic Struggles Behavioral Issues Delinquency Self-Esteem

Vocational Needs Social Skills Peer Relationships Family Issues Special Needs Other:

Availability of Child *(check all that apply)*: Daytime Traditional after school Modified after school Weekends

Mental Health & Medical Diagnoses:

History of Suicide/Self-Harm:

History of Danger to Others/Animals:

Inclusionary Criteria *(check all that apply)*:

The child is continent of bowel and bladder.

The child understands verbal prompts and is able to communicate.

The child has not presented with problem sexual behavior.

The child has not demonstrated physical aggression toward any professional in the past 3 months.

Billing and Team Organization

Referring Agency: Contact Person:

Phone: Email:

Billing Type: CCS *(please provide current ISP/CORE Assessment)* WPS County Other:

Anticipated/Initial Estimation of Authorized Hours*: weekly monthly yearly

Billing Contact: Referring agency Separate agency *(name & email)*:

Client Team Meetings Occur: Monthly Quarterly As needed Other:

**Authorization requested when child is matched with mentor. Service will begin once authorization provided to mentoring@trinity-ec.com*