

**Referral Form**

Please check one Referral type and include two copies of all requested documents.

<input type="checkbox"/> <b>Life Skills</b> (Youth in foster care, 14 to 21 Years of Age) Referral Packets shall include two copies of the following documents: <input type="checkbox"/> <b>CFS 912, Referral Form</b> (All requested information must be entered on the completed form.); <input type="checkbox"/> Face sheet and child specific section of current SACWIS service plan; <input type="checkbox"/> Integrated Assessment; <input type="checkbox"/> <u>scored</u> Casey Life Skills Assessment <input type="checkbox"/> <b>CFS 600-3, Consent for Release of Information</b> , signed by the youth and/or authorized agent of the Guardianship Administrator.
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<input type="checkbox"/> <b>Financial Literacy Education</b> (Youth in DCFS managed placement, within 30 days of attaining 19 years of age) Referral Packets shall include two copies of the following documents: <input type="checkbox"/> <b>CFS 912, Referral Form</b> (All requested information must be entered on the completed form.); <input type="checkbox"/> <b>CFS 600-3, Consent for Release of Information</b> , signed by the youth and/or authorized agent of the Guardianship Administrator.
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Completed referral packets must be submitted to the appropriate Transition Manager of the Office of Education and Transition Services (OETS). Please do not fax life skills referrals.

**OETS TRANSITION MANAGERS**

**Cook Region**

OETS Transition Manager  
DCFS  
6201 S. Emerald Drive  
Chicago, Illinois 60621  
773-371-6423

**Northern Region**

OETS Transition Manager  
DCFS  
8 E. Galena Blvd., Suite 300  
Aurora, Illinois 60506  
630-801-3446

**Central & Southern Region**

OETS Transition Manager  
DCFS  
2309 W. Main Street, Suite 108  
Marion, Illinois 62959  
618-993-7100

**CASEMANAGER DATA**

Date:	Name of DCFS/POS Worker:
Worker's R/S/F:	Worker's e-mail address:
Worker's Agency:	
Worker's Address (Street, City, State & Zip):	
Telephone: (     )     -     -	Facsimile: (     )     -     -
Supervisor's Name:	Telephone: (     )     -     -

**YOUTH DATA**

Youth's Name:	DOB:	Age:
DCFS ID:	Telephone: (     )     -     -	Cell phone: (     )     -     -
Youth's Address (Street, City, State & Zip):		
County:	Youth's email address:	
Youth's signature:		

**PLACEMENT DATA**

Contact Name:	Relationship:
Address (Street, City, State & Zip):	
Home Telephone: (     )     -	Work or Message Telephone: (     )     -
Email address:	

Describe any safety related concerns.

Are there any transportation issues? How will the youth get to classes?

When is the youth available to participate in classes (i.e., Wednesday evenings, Saturday mornings)?

Does the youth have any behavioral/emotional problems? Include clinical diagnosis and medications, if applicable.

What is the youth's learning style?     Auditory     Visual     Participatory

Does the youth have a physical disability?     Yes     No

Type of disability: \_\_\_\_\_

Date Received:	Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No	Pended: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date _____	Date _____
Assigned Provider:		
Signature of Transition Manager:		