



**REFERRAL FORM**  
**Contact: Carl Stewart**  
**Phone: 888-8324**  
**Fax: 888-8136**  
**E-mail: cstewart@chslv.org**

**Lamoille Valley  
Youth in Transition**

**Eligibility Information: *MUST MEET ALL OF THE FOLLOWING CRITERIA (exceptions on a case-by-case basis)***

- 16 up to age 22 year old experiencing or at-risk of mental health or substance abuse
- Case requires a high level of case coordination
- At-risk of or already intersecting with criminal justice

**Case Information**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Age: \_\_\_\_\_  
Gender: \_\_\_\_\_ Phone: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ DOB: \_\_\_\_\_

**Referral Information**

Name/Agency: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- Reason for Referral:
- |  |  |
|--|--|
| <input type="checkbox"/> Housing                               | <input type="checkbox"/> SSI/SSDI                            |
| <input type="checkbox"/> Transportation                        | <input type="checkbox"/> Education                           |
| <input type="checkbox"/> Medical Insurance                     | <input type="checkbox"/> Disability                          |
| <input type="checkbox"/> Medical Care                          | <input type="checkbox"/> Legal                               |
| <input type="checkbox"/> Dental Care                           | <input type="checkbox"/> Self-help                           |
| <input type="checkbox"/> Child-Related (Child care, parenting) | <input type="checkbox"/> Socializing                         |
| <input type="checkbox"/> Employment                            | <input type="checkbox"/> Domestic Violence                   |
|  | <input type="checkbox"/> Lack of Stable Caring Relationships |

Brief consultation about client:

**YIT Use Only**

Date Received: \_\_\_\_\_ Accepted? **Yes or No (Circle one)** \_\_\_\_\_  
ID \_\_\_\_\_ Date Intake/Ref: \_\_\_\_\_