Volunteers of America
MINNESOTA AND WISCONSIN

Bar None ShelterPlus

Referral Information Checklist

Include the following information when making a referral to Bar None ShelterPlus:

- ☐ Completed Referral Form – Please provide as much information as possible
- ☐ Relevant legal documentation
  - Court Order/OHP documentation
  - Signed release(s) for county worker/referring agency (social worker/probation officer/CMH case manager)

Please note: Additional information may be requested to complete the review process, such as a DA, IEP/IEP evaluation, or psychological evaluation.

Send completed referral form and documentation to:

Bar None ShelterPlus: Sara Ellis
Phone 763-252-4541, Fax 888-965-5125
Email sara.ellis@voamn.org
Address 22426 St. Francis Blvd, Anoka MN 55303

Prior to admission, the following documents may also be requested:

- ☐ Copies of insurance cards
- ☐ Most recent Individualized Education Program (IEP), including any testing or assessment done by the school district
- ☐ Additional documents and/or signed releases to request the following clinical information (resident signature is required for clients over 16):
  - All previous psychological/neuropsychological testing reports
  - All medical health records, including verification of current medications (if applicable)

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Resident Facesheet & Referral Form

Date:

Client Information				
First Name:	**Middle Name:**		**Last Name:**	
Date of Birth:	**Age:**	**Sex:**	**Preferred Pronouns:**	**Nickname:**
Address:			**SSN:**	
City: **State:** **Zip code:**			**Place of Birth:**	
Referral source:		**Child's Current Location (home, hospital, shelter, etc.):**		
Languages Spoken/Written:				
Identifying Characteristics (hair/eye color/tattoos etc.):				
Race/Cultural Heritage/Native American Tribal Affiliation/Religious or Spiritual Affiliation:				
Mother's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Father's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Other/Guardian's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Is the child adopted? ☐ **Yes** ☐ **No**	**At what age?**			
Legal Custody: ☐ **Mother** ☐ **Father** ☐ **Joint** ☐ **Other (specify):**			**Physical Custody:** ☐ **Mother** ☐ **Father** ☐ **Joint** ☐ **Other (specify):**	
☐ **I have provided a copy of custody paperwork (if applicable).** **(initials)**			**Placement Authority:** ☐ **Court Ordered OHP** ☐ **Voluntary OHP** ☐ **Other**	
Is anyone restricted from contact with the child? ☐ **Yes** ☐ **No**		**Name:**		**Relation:**

County Contact Information (Please indicate primary worker)		
Social Worker Name:	**County:**	**Contact in an emergency?**
Address:	**Phone:**	☐ Yes ☐ No
Email:	**Fax:**	
Probation Officer Name:	**County:**	**Contact in an emergency?**
Address:	**Phone:**	☐ Yes ☐ No
Email:	**Fax:**	
Children's Mental Health Case Manager:	**County:**	**Contact in an emergency?**
Address:	**Phone:**	☐ Yes ☐ No
Email:	**Fax:**	

Referral Information	
Reason for Shelter Placement:	
Placement Goal After Shelter:	

Insurance Information		
Primary Health Insurance:		**Subscriber Name:**
Policy or ID#	**Group:**	**Phone:**
Financially Responsible Party (parent/guardian/county etc.):		**MA#:**

Office Use Only Below

Client Number/Unit: Norris Lake

Admission Date/Time:

Case Coordinator:

Discharge Date: TBD

Revised 3/08/19, 8/6/19, 10/23/19, 11/26/19, 3/18/20, 7/16/20

Trauma History	
Please identify any chemical use in home, neglect, physical abuse, emotional abuse, sexual abuse, exploitation/victimization, other trauma exposure, etc.	

Mental Health & Behavioral Health History	
Does this client have a history of hallucinations/delusions?	☐ Yes ☐ No
Does this client have a history of SI/SIB?	☐ Yes ☐ No
Does this client have a history of running from placement?	☐ Yes ☐ No
Does this client have a history of assaultive/destructive behavior?	☐ Yes ☐ No
Does this client have a history of substance use?	☐ Yes ☐ No
Does this client have a history of perpetrating sexual abuse?	☐ Yes ☐ No
Does this client have a history of false reporting?	☐ Yes ☐ No
Is youth an adjudicated delinquent or do they have a history of delinquency?	☐ Yes ☐ No
If you answered "yes" to any of the above questions, please provide details in the appropriate boxes.	
Client's strengths and assets:	

Placement History & Previous Interventions	
Please list previous placements/interventions:	

Medications & Medical History			
Current medications:			Are any given by injection? ☐ Yes ☐ No
Prescribing doctor:		Phone:	
Address:		Fax:	
Allergies (Food, Animal, Medication):	☐ Yes ☐ No Do they have an EpiPen? ☐ Yes ☐ No		
*List allergies/reactions:			
History of Asthma:	☐ Yes ☐ No Do they have an inhaler? ☐ Yes ☐ No		
Health Concerns (TBI, seizures, diabetes, broken bones, braces on teeth, cardiac issues, mobility issues, eating disorders, etc.):	☐ Yes ☐ No *If yes, please explain:		
Has the client ever had a positive Mantoux (Tuberculosis) test?	☐ Yes* ☐ No *If yes, a chest x-ray is required before admission*		
Serious, Chronic or Communicable Diseases:	☐ Yes* ☐ No *If yes, please explain:		
Special Dietary Requirements:	☐ Yes* ☐ No *If yes, please explain:		
Any possibility the client may be pregnant? ☐ Yes* ☐ No *If yes, approximately how far along are they or when is their due date?			
Last Physical:	Last Eye Exam:	Last Dental:	
Are there any pending or ongoing medical appointments? ☐ Yes ☐ No Please explain:			
Are you seeking onsite psychiatric care/consult/medication management? (provided through VONA) ☐ Yes ☐ No			

Educational Information	
Last school attended:	Current Grade: IQ: Home School District:
Address:	Individualized Education Plan (IEP)? ☐ Yes ☐ No Type:
Do you want to enroll the client in ISD 15 – Crossroads while at Bar None or remain enrolled with school of origin? ☐ Crossroads ☐ School of Origin:	

Immediate Needs
Is assistance needed in obtaining therapeutic services? ☐ Yes ☐ No If yes, please see attached "Therapeutic Services" form.
Anything else we should know?

Name of person filling out application:	Date:	Signature:
For Guardians: On behalf of VOA, we would like to place your child in the most appropriate program. Therefore, we would like your permission to share information between all sites and will determine the most appropriate program for your child/youth based on the information provided. Do you agree for information to be shared between VOA's residential programs? ☐ Yes ☐ No		
Legal Guardian's Name:	Date:	Signature:

Therapeutic Services (Optional)
ShelterPlus has partnered with VONA Center for Mental Health and Natalis Counseling and Psychology. These partnerships allow our ShelterPlus program to coordinate the following services on-site at our facility. Please indicate if youth needs any of the following: ☐ **Diagnostic Assessment** ☐ **Psychiatric Evaluation** ☐ **Medication Management** ☐ **Psychological Testing** ☐ **Psychosexual Assessment** ☐ **Sexual Health Evaluation** ☐ **Individual Therapy** ☐ **Family Therapy** **Each of these services are available on-site, provided by external providers and require a referral from the assigned Youth Case Coordinator. Each service is either billed through insurance or paid for by the placing authority. Telehealth options are also available and utilized as needed.**

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Referral Review Form

<table>
<tr><th colspan="4">Client Information</th></tr>
<tr><td>First Name:</td><td colspan="2">Middle Name:</td><td>Last Name:</td></tr>
<tr><td>Date of Birth:</td><td>Age:</td><td>Sex:</td><td>Insurance:</td></tr>
<tr><th colspan="4">Review</th></tr>
<tr><td colspan="3">Current Diagnosis (if applicable):</td><td>CD Concerns? ☐ Yes ☐ No</td></tr>
<tr><td>Reason for Referral:</td><td colspan="3"></td></tr>
<tr><td>Discharge Plan/Goal:</td><td colspan="3"></td></tr>
<tr><td>Strengths:</td><td colspan="3"></td></tr>
<tr><td>Trauma History:</td><td colspan="3"></td></tr>
<tr><td>Initial Concerns (e.g. cognitive functioning, concerning behaviors, etc.):</td><td colspan="3"></td></tr>
<tr><td>Interventions:</td><td colspan="3">• Immediate Needs Assessment and Plan
• Casey Life Skills Assessment
• Functional Assessment with Service Recommendations
• Individualized Skills Service Plan
• Supportive Living Environment
• Positive Reinforcement Programming
• Shelter-based Case Management Services
• 24-hour Licensed Mental Health Professional Oversight
• Experiential, Psychoeducational and Skills Groups
• Daily Recreational Activities and Development
• Daily Living Skills Practice and Development
• On-site Education with Special Education Services or assistance in coordinating with home district
• Individual and Family Skills Services
• On-site Nursing (business hours) with 24-hour phone consultation
• Crisis Intervention, Stabilization and Counseling Services</td></tr>
<tr><td>Initial Reviewer:</td><td></td><td>Review Date:</td><td></td></tr>
<tr><td>Reviewer Signature:</td><td></td><td>Date:</td><td></td></tr>
<tr><td>Immediate Needs:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Is program appropriate:</td><td>☐ Yes ☐ No</td></tr>
<tr><td colspan="3">Is program able to meet client’s cultural, emotional, educational, mental health, chemical and physical needs:</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Final Reviewer:</td><td></td><td>Review Date:</td><td></td></tr>
<tr><td>Reviewer Signature:</td><td></td><td>Date:</td><td></td></tr>
</table>