



### Mandated Assistance Program Referral Form

Please fill out as completely as possible and fax this form to the M.A.P. coordinator at 310-247-1491

#### Student & Referral Information:

Student Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
 School Name: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_ Referral Date: \_\_\_\_\_  
 Student's Mother: \_\_\_\_\_ Student's Father: \_\_\_\_\_  
 Phone (home): \_\_\_\_\_ Phone (home): \_\_\_\_\_  
 Phone (cell/work): \_\_\_\_\_ Phone (cell/work): \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_

Where does student live:  Home w/ both parents  Home w/mother  Home w/father  Boarder  Other  
*If checked boarder or other please write contact information below:*

Name(s) of who student lives with: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work/cell Phone: \_\_\_\_\_

#### Reason for Referral (why substance use is suspected):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### Observations:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Change of friends         | <input type="checkbox"/> Excessive lying           | <input type="checkbox"/> Unhappy/depressed  | <input type="checkbox"/> Appears Tired   |
| <input type="checkbox"/> Unexplained grade changes | <input type="checkbox"/> Blood shot eyes           | <input type="checkbox"/> Explosive          | <input type="checkbox"/> Poor Hygiene    |
| <input type="checkbox"/> Unexplained/many absences | <input type="checkbox"/> Dilated pupils            | <input type="checkbox"/> Hyperactive        | <input type="checkbox"/> Cheats/steals   |
| <input type="checkbox"/> Odor of alcohol/drugs     | <input type="checkbox"/> Reported using            | <input type="checkbox"/> Lacks Control      | <input type="checkbox"/> Self-disclosure |
| <input type="checkbox"/> Mood swings               | <input type="checkbox"/> Significant weight change | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Other           |

If you have checked any of the above, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please include information about student's family history, academic performance, social skills, and any other information about student that may be relevant : \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# { ALEINU } FAMILY RESOURCE CENTER

## MANDATED ASSISTANCE PROGRAM PARENT CONSENT FORM

Dear Parent,

The Jewish Family Service Aleinu Family Resource Center provides comprehensive assessment and *short-term* school-based counseling to youths and their families in order to help them cope with a variety of concerns, both individual or school-related. Your son/daughter may be referred to the Jewish Family Service Aleinu Family Resource Center to determine if he/she might benefit from our services. One of our services, upon referral from the school, is a comprehensive substance use assessment. This assessment may include drug testing and/or treatment recommendations. These recommendations may include short term individual, family, and/or group counseling. If your child is referred for assessment, you are required to participate in the assessment process and be actively involved in treatment recommendations. A fee of \$200.00 will be assessed for this service.

As part of the City-Wide Mandated Assistance Program (M.A.P.), all Aleinu schools are requiring parent signatures as an indication that parents have read, understood, and consented to the Mandated Assistance Program and discussed it with their child. Please sign this form and have your son/daughter return it with any other accompanying forms, as soon as possible. Should you have any questions regarding our program or if you would like further information, please feel free to contact our staff or your school principal.

Sincerely,

Principal

Deborah Fox, LCSW  
Program Director, Aleinu Family Resource Center

I, \_\_\_\_\_, have read and understood the Mandated Assistance Program and discussed it with my child \_\_\_\_\_. If my child is referred to M.A.P., I agree that they will participate in the assessment process. I also agree to participate in my child's assessment process and be actively involved in treatment recommendations.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_

Work: \_\_\_\_\_