



# Youth Provider Referral for Youth Services



Customer Name (First, Middle, Last):

Last 4 SSN

Address (Street, City, Zip)

Email Address

Phone Number

Alternate Phone Number

## Referring Provider Information

Was a CalJOBS registration completed?

If no, please explain:

Yes

No

Referred From (Organization)

Contact Person

Phone Number

Email Address

Eligibility Barriers

Preferred Youth Provider Requested

I understand that by signing below, I authorize the referring Agency/Individual Provider to release information about me to other San Bernardino County Youth Providers. I understand this release will remain in effect, until I choose to revoke it.

Customer Signature

Date

## Organization Referred To (To be completed by WDD Administration)

Referred To (Organization)

Date Referred

Referred By

Phone Number

Email Address