Services Referral Form
Southern Illinois Violence Prevention Project

Date:____/____/_____

Name:_____Parent/Guardian Name:_____

Street Address:_____City:_____Zip Code: _____

County of Residents (Select One):

☐ St. Clair ☐ Saline ☐ Marion
☐ Jefferson ☐ Jackson ☐ Franklin

Phone: (Home) (____)_____- _____ (Cell) (____)_____- _____

Gender: _____ Ethnicity: _____ Date of Birth:____/____/_____(12 – 24-year-olds only)

Probation Involvement (Select One):

☐ On Probation ☐ In Redeploy ☐ None

Health Insurance Coverage (Select One):

☐ Medicaid ☐ Private Insurance ☐ None
Company Name: _____

Summarize reason for referral:

_____
_____
_____
_____

Eligibility Criteria:

☐ Screened with Adverse Childhood Experiences Survey with a score of____(≥ 4 = Automatic eligibility)

Optional Supplemental Eligibility Criteria:

☐ Screened with the CPSS-5 with a score of____(≥ 31)
☐ Screened with PSS- 5 with a score of____(≥ 23)
☐ Screening scores are not considered valid or other circumstances warrant consideration for acceptance.
☐ Screening has not been conducted

Referent's Information

Name of Person Referring: _____ Contact Number: (____)_____- _____
Email Address: _____

Referral Agency or type of referral?:

☐ Self or Family Referral ☐ School ☐ Medical Provider
☐ Court Services ☐ JJ Council ☐ Other Justice Organization
☐ MH/SA Agency ☐ Child Welfare ☐ Other: _____

Additional Notes or Recommendations:

_____
_____

Send Completed Forms to Matt Buckman, SIVPP Clinical Director
dmattbuckman@gmail.com using Virtru or Fax to (618) 216-9993