



# THERAPY FUND REFERRAL FORM – FOR ABUSE VICTIMS

REFERRAL DATE \_\_\_\_\_

REFERRING PARTY \_\_\_\_\_

POSITION \_\_\_\_\_

STUDENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

SCHOOL \_\_\_\_\_

PARENT \_\_\_\_\_

ADDRESS  
\_\_\_\_\_  
\_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**Please answer the following questions if the information is available.**

Is the family involved with the Department of Social Services for issues of Maltreatment, Dependency, and/or Neglect? \_\_\_\_\_

Does the child/adolescent have current legal involvement? \_\_\_\_\_

Has the child/adolescent had inpatient, residential, or day treatment for psychiatric problems in the last 6 months? \_\_\_\_\_

Will the child/family need a Spanish-speaking therapist? \_\_\_\_\_

**STUDENT MUST FIT INTO ONE OF THE FOLLOWING CATEGORIES TO QUALIFY FOR THE VICTIMS ASSISTANCE GRANT FUNDING.**

PLEASE CHECK APPROPRIATE CATEGORY (NEED ONLY ONE CATEGORY TO QUALIFY)

Aurora Public School Students Who:

- \_\_\_\_\_ 1. Are victims of abuse (past or present) and do not qualify for other forms of therapy assistance, i.e.: Medical Insurance, Medicaid, Self Payment, Victim’s Compensation, etc.
- \_\_\_\_\_ 2. Would have been eligible for counseling help from Victim’s Compensation Funds had a police report been filed. i.e.: a personal assault or domestic violence incident.
- \_\_\_\_\_ 3. Family members were victims or witnesses to violent crimes of all kinds, but whose allotment of Victim’s Compensation Funds have been exhausted prior to the need for counseling.
- \_\_\_\_\_ 4. Are identified as perpetrators of sexual abuse on other children, for whom we have history of victimization as well as perpetration, who therefore need counseling to deal with both issues.

REASON FOR REFERRAL  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IS THE PARENT MOTIVATED FOR THE CHILD TO RECEIVE THERAPY  
\_\_\_\_\_  
\_\_\_\_\_

IS TRANSPORTATION AVAILABLE \_\_\_\_\_

OTHER COMMENTS  
\_\_\_\_\_  
\_\_\_\_\_

**THERAPY SESSIONS MUST BEGIN WITHIN ONE MONTH OF APPROVAL DATE**

**MUST ATTACH A RELEASE OF INFORMATION FORM SIGNED BY PARENT:** (I will fill out name of therapist later if you do not Have when parent signs form.)

Thank you. Please return to: Katie Bernard at Educational Services Center, Building 3  
Phone: 303 365-7813 x28513  
Fax: 303 326-1268  
Pager: 303 207-5187