

Mentoring Referral Form

Referral Date: _____ Referring Children's Division Worker: _____

County _____ Phone Number _____

Units Requested per week: _____

**A unit is *50 minutes of face to face contact with only one child per Mentor per unit of service;*

**Cost of service includes any costs of transportation to and from the home or community resource*

Date Services are to Begin: _____

*Please attach CD Authorization for MENT Service :

(Supplementary Children's Services; Contract # SDA3999049; Vendor # 000669272) Code: MENT

List any concerns of which Mentor should be aware during the session ie: violence; weapons; dangerous animals; etc)

Client being Referred: (Client must be 14 years of age or older unless otherwise approved by the Circuit Manager or designee)

Name

Address

Phone Number

Address *or detailed directions to location where Mentor will initiate Mentoring Services if different from above address

Individuals expected to be present during the Mentoring session and their *relationship to the client(s)* being referred?

**Only the individuals listed will be permitted to be present during the Mentoring session*

Treatment Goals: ie: How would you expect this client to benefit from having this Mentoring experience?

Special instructions to the Mentor regarding delivery of Mentoring service:

Detailed notes of each Mentoring session as well as any suggestions for follow-up are made available to the CD Worker in a timely manner after each Mentoring session. Please indicate below any additional requests regarding documentation:

GRCC Policy Regarding No-Show or Canceled Visits:

*There is no charge for "no shows" or "cancellations".

*Sessions are counted as "no shows" or "cancellations" if client is more than 20 minutes late or cancels with less than a 24 hour notice to Mentor prior to scheduled visit time.

*Sessions are terminated after two consecutive "no shows" or "cancellations" until there is a significant change in the client's circumstances