

## GROW ACADEMY REFERRAL AND FACE SHEET

Return this form, with required referral documentation to: Grow Academy Supervisor at [GrowAcademy@wisconsin.gov](mailto:GrowAcademy@wisconsin.gov)

**IDENTIFYING INFORMATION:** Referral From  COUNTY  DJC  OTHER:

NAME OF YOUTH (First, M.I. Last)

ALIAS(ES):

DOC NUMBER (if assigned):	SID NUMBER (if assigned):	DATE OF BIRTH (mm/dd/yy)	AGE	CO. OF COMMITMENT	SCHOOL YOUTH WILL ATTEND AT DISCHARGE	DOES / DID YOUTH HAVE AN IEP <input type="checkbox"/> Yes <input type="checkbox"/> No
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RACE SELECT	ETHNICITY: Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	HT:	WT:	HAIR COLOR:	EYE COLOR:
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TATTOOS, MARKS, or SCARS, ETC.

NAME OF FATHER	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
NAME OF MOTHER	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	
ADDRESS (if different from the father)	CITY	STATE	ZIP CODE
NAME OF GUARDIAN (if applicable)	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
COMMITTING COURT	EXPIRATION DATE	ELIGIBLE START DATE	

OFFENSE(S) to include prior, current, pending offense(s)

RISK LEVEL  HIGH  MEDIUM  LOW  N/A

CHECK ALL THAT APPLY:  AWOL RISK  PHYSICALLY ASSAULTIVE HISTORY  CRUELTY TOWARDS ANIMALS  
 SELF HARM HISTORY  HISTORY OF INAPPROPRIATE SEXUAL BEHAVIOR  MENTAL HEALTH HISTORY

NAME OF HEALTH INSURER (Dean, Unity etc.)	SUBSCRIBER NAME	GROUP NUMBER	
NAME OF DENTAL INSURER (Dean, Unity etc.)	SUBSCRIBER NAME	GROUP NUMBER	
NAME OF STATE AGENT OR COUNTY SOCIAL WORKER	WORK TELEPHONE NUMBER	ON-CALL TELEPHONE NUMBER	
FAX NUMBER	E-MAIL ADDRESS		
ADDRESS (WORKSITE)	CITY	STATE	ZIP CODE
NAME OF DJC SOCIAL WORKER (DJC Only)	WORK TELEPHONE NUMBER (Include Extension Number)		

POSSIBLE RELEASE PLANS (If youth is successful in this program):

ALTERNATE PLANS (If youth is unsuccessful in this program)

**COMMENTS** (Exclude personal health information), Physician Name & Address and Dentist Name & Address (if applicable).

**OJOR APPROVED (DJC Only)**  Yes  No