NorthStar Summer Program Application

This form is for referring children for possible participation in NorthStar Summer Program and grants permission for information to be shared between the person or agency making the referral and Northwestern Mental Health Center, Inc. **This form must be completed with, or by, a parent/guardian of the child being referred.** The parent/guardian will be notified by NorthStar staff if the child has been accepted or not accepted to the program.

Release of Information: I, the parent/legal guardian of_____, do hereby give permission for information about my child to be shared with Northwestern Mental Health Center, Inc. in order to be referred and considered for possible admission to NorthStar Summer Program. I also give permission for NorthStar staff to contact me.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

Date of Referral: _____Name of referring person and agency_____

Please complete this form and return to: NorthStar Summer Program by February 28, 2014

By mail: NorthStar Summer Program
603 Bruce Street Crookston, MN 56716
Fax: (218) 281-6261
E-mail: NSSP@nwmhc.org

Dates of NorthStar: Monday/Wednesday sites start June 9th and end August 13th.
Tuesday/Thursday sites start June 10th and end August 14th.

NorthStar site locations: **Sites are assigned based on nearest location to where child lives.**

Karlstad, Warren, East Grand Forks, Crookston, Red Lake Falls, Plummer, Erskine, Fosston, Fertile, Ada, Twin Valley, Mahnomen.

Childs Name _____ Date of Birth _____
School attending _____ Current grade_____
Address _____ City/Zip _____
Parent/Guardian name_____ Home phone_____
Cell phone_____ Best time to call _____ OK to leave message? ☐ Yes ☐ No

Does the child receive any of the following services? (**Check all that apply**)

☐ Medical Assistance	☐ Personal Care Assistant (PCA)	☐ Para-Professional
☐ County Case Management	☐ Out-Patient Therapy/Counseling	☐ Probation
☐ School Based Mental Health Services	☐ Individual Education Plan (IEP)	☐ 504 Plan

Has a diagnostic assessment been completed for the child? ☐ Yes ☐ No Date completed: _____

What agency completed the diagnostic assessment? _____

What diagnosis was given? _____

Please describe the areas of concern you have for this child, leading to this referral: (form will expand as you type, or continue on back of page.)

Office Use Only
Funding Source: _____