IOWA Health and Human Services

Iowa Department of Health and Human Services

Pre-Aftercare Referral Form

"Pre-Aftercare Services" means services provided to youth age 17, who are expected to qualify for the Iowa Aftercare Services Program (Aftercare), prior to their discharge from foster care, the State Training School, or detention. Pre-Aftercare Services allow the youth to begin a relationship with Aftercare staff in addition to allowing Aftercare staff to provide services to assist the youth with a more seamless transition to Aftercare. Direct contacts tend to be infrequent and are delivered "as needed". Services provided cannot duplicate or supplant services of which the youth is already receiving. Pre-Aftercare Services may include Substantial Contacts and indirect activities to support the youth, such as attending planning meetings, coordinating housing, and attending youth centered meetings for the child. Pre-Aftercare Services is also called pre-services.

Youth Information		
Name	Date of Birth	State ID
Best way to contact youth (provide phone or email)		
Sex *(may decline to answer)*	Race/Ethnicity *(how youth identifies/may decline to answer)*	Primary language Translation services needed?
County Youth Expected to Live after Discharge	Expected Discharge Date (*MM/YYYY*)	Current Voluntary Placement Agreement (VPA) (*Yes/No*)
Education Level (*grade*)	Special Education (*Yes/No*)	Expected H.S. Graduation Date *(mm/yyyy)*

Current Placement		
Type	Agency name/caregiver name	
City and County	Email	Phone
Case Life Skills Assessment Date completed by youth: How to access a copy (attach if available):	Pending court issues or protection orders	

Supports – Service Providers and Informal Connections		
Family-Centered Services	Next YTDM OR YCPM (Date and Facilitator)	
IHH	BHIS	Adult Services
Other supports, such as kinship connections, mentors, or peers		

Additional Information
Provide information to inform service delivery (e.g., transition plan, Casey Life Skills Assessment, youth's interests, behavior issues, etc.). Documents referenced should be attached this referral, if available, or indicate who created them in this field.

Referring Worker Information		
Date (*MM/DD/YYYY*)	Service Area Name/Judicial District Number	
Referring Worker Name	Phone	Cell Phone
Email	County	City, State

Send completed referral form to Joanie Havel, IASN Coordinator, at: jhavel@iastate.edu