Omaha Home *for* Boys

•FOUNDED IN 1920•

Branching Out Program

Preparation • Transitional Independent Living Services

RELEASE OF INFORMATION
FOR BRANCHING OUT PROGRAM PARTICIPATION

I _____ herby, give my consent to Branching Out staff member to consult with the below agencies for the purposes of coordinating services, consultation or exploring additional resources which may benefit the said person.

- ☐ **Nebraska Department of Health and Human Services**
- ☐ **Goodwill Industries (Partnership and Youth build Programs)**
- ☐ **Child Saving Institute**
- ☐ **Heartland Family Services (Housing services)**
- ☐ **Nebraska Children and Families Foundation (Youth Council and Project Everlast)**
- ☐ **One World Community Health Center (Medical/Mental Navigation)**
- ☐ **Charles Drew Health Center (Medical Navigation)**
- ☐ **Jacobs' Place Independent Living Program**
- ☐ **One World Community Health Center**
- ☐ **Other_____**

_____ Youth's Full Name

_____ Date of Birth

_____ Signature/Title of Lead Agency Representative

_____ Date

_____ Address

_____ Phone

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Consent to Serve

I _____, hereby give Omaha Home for Boys authorization to provide Preparation, Transitional, Independent Living services. All services are provided through the Omaha Home For Boys Branching Out Program.

_____	_____
Youth's Full Name	Date of Birth
_____	_____
Signature/Title of Lead Agency Representative	Date
_____	_____
Address	Phone

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Branching Out

REFERRAL INFORMATION FORM

Date:
Client or Family Name: Master Case #:
Date of Birth: **Age:**

*Date/Time/Location of Next Family Team Meeting:
*If one isn't scheduled, date of most recent Team Meeting:

Adult requesting services: Title:

YOUTH INFORMATION

Address: City: State: Zip:

Telephone Number:

Name of Care Giver/If facility, Contact Person:

Dates of State Custody: to ongoing ☐

☐ Male ☐ Female SSN: _____-_____-_____

Race: ☐ Pregnant ☐ Parenting ☐ Married ☐ Single

TYPE OF CASE: ☐ Neglect/Abuse ☐ Status ☐ Adoption ☐ OJS

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REASON FOR REFERRAL: (see program component descriptions)

☐ Preparation ☐ Transition ☐ Community Support, Independent Living
☐ Intensive Comm. Support ☐ After Care

Youth Employed? ☐ Full-Time ☐ Part-Time ☐ Summer Only ☐ None

Attending School? ☐ Yes ☐ No
*if **yes**, indicate location:
Education Grade Level (Check One)
☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ G.E.D. ☐ Graduated ☐ College

Current Living Arrangement: ☐ Independent Living ☐ Foster Care
☐ Agency Based Foster Care ☐ Relative
☐ Group Care Facility ☐ Non Relative/Friend
☐ Other:

Special Needs? ☐ Learning Disabilities(IEP attached)

☐ Mental Health History Medications:

☐ Behavior Problems:

☐ SSI ☐ Developmental Disability Services ☐ SSA

☐ Physical Disabilities(Specify)

☐ Other (Describe):

Is there a safety plan that Branching Out staff need to be made aware of? Y ☐ N ☐
*If yes, please attach

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CONTACT INFORMATION

Agency:	
Family Permanency Spec:	Phone:
Address:	Email:
	Phone:
Family Permanency Supr:	Email:
CFS/ CFOM (DHHS):	Phone:
Address:	Email:
Emergency Contact:	Phone:
Relationship:	Email:
Address:	

COURT INFORMATION

County: ☐ Douglas ☐ Sarpy Judge: County Attorney: GAL: Parent's Attorney:	Summary:
Date of most recent hearing:	Date of next hearing:

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PARENTAL INFORMATION

Mother Name:	Include in Team Planning Sessions? Y / N
Primary Parent: Y / N	Race:
Address:	Phone:
Parent's Availability for Services:	
Any contact restrictions with children, family, or other members?	Criminal history/safety concerns for provider to be aware of?
Father Name:	Include in Team Planning Sessions? Y / N
Primary Parent: Y / N	Race:
Address:	Phone:
Parent's Availability for Services:	
Any contact restrictions with children, family, or other members?	Criminal history/safety concerns for provider to be aware of?

INFORMATION OF ALL CHILDREN IN THE FAMILY

Child's Name	Date of Birth	Current Location/Address/Phone	School/Grade

PERSONAL CONNECTIONS(Example-Foster Parent, Mentor, Teacher, Significant Others)

Name	Role	Address with Zip Code	Phone Number

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TEAM PLANNING INFORMATION:

Are There Significant Others to be Included in the Team Planning Session? ☐ Yes ☐ No

Include Parent/Guardian? ☐ Yes ☐ No *List those to be included not previously listed.*

Name Relationship Phone

Name Relationship Phone

INDEPENDENT LIVING NEEDS

Preparation, Transitional, Independent Living Skills

☐ Housing ☐ Transportation ☐ Employment ☐ Education
☐ Money Management ☐ Daily Living Skills

☐ Other, Describe:

SPECIFIC SERVICE GOALS

1	
2	
3	
4	
5	

If outside scope of services, our recommendations:

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Referral Check list:

- Completed referral aplication
- Autherization of services form complete
- Consent Form Complete
- Ansell Casey if **applicable**

Please return completed referrals to njensen@omahahomeforboys.org or fax to (402)457-7167

Once all information is complete, Branching Out will do our best to make contact with the referring agency and youth within three business days.

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Brief Description of Program Components:

- **Preparation Services**-Youth between the ages of **14 and 19** who are more than six months from transitioning to independence but need assistance with independent living planning/skill development can receive preparation services. The support will focus less on specific goal areas and more on general skill development and enhancement of knowledge (career exploration, cooking skills, job readiness, etc.). In this support area, IL Specialists will work with current service providers such as foster parents, group home staff and service coordinators to address needs in the areas of independent living. The IL Specialist will not provide one-on-one support; rather the service providers will be responsible for the implementation of the agreed upon independent living plan. Contact will generally occur *quarterly* with IL Specialists.
- **Transitional Services**-Youth between the ages of **16 and 18**, who are within six months of transitioning to independent living, are eligible for this support component. The support will focus on helping youth in meeting specific goals that need to be accomplished in order to transition to independence. Contact with IL Specialist will generally occur 2-3 times per month, depending on the needs of the individual.
- **Intensive Independent Living Services**-This component is designed for youth ages **17-22** that need a significant amount of support to maintain independence. These youth may not qualify for adult services (mental health/DD) but do have significant barriers to achieving self-sufficiency. It is likely that additional service providers will be necessary to ensure these young people successfully transition to independence.
- **Supportive Independent Living Services**-This component will meet the needs of youth, ages **17-23**, who with a minimal amount of supervision can be successful at achieving self-sufficiency. These youth may have some financial assistance, such as independent living funds, former ward funds, but generally are able to meet their financial obligations on their own. They are also able to demonstrate a willingness and motivation to reach their independent living goals. Similar to transitional services, contact with IL Specialist will generally occur 2-3 times per month, depending upon youth needs.
- **After-care independent Living Services**-This component allows for continued contact with the youth on a monthly or bimonthly basis. This is a support component where the youth and IL Specialist can problem solve, celebrate accomplishments and plan next steps.

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