

Connecticut Department of Children and Families
ONE-ON-ONE MENTORING PROGRAM EXCEPTION FORM

DCF-105
 3/17 (Rev.)



Page 1 of 1

DCF Area Office:		Date:		Case ID #:	
Youth's LAST Name:		Youth's FIRST Name:		Person ID #:	
Race:		Ethnicity:		DOB:	
Primary Language:		English Proficiency: <input type="checkbox"/> Basic <input type="checkbox"/> Intermediate <input type="checkbox"/> Advanced		Phone:	
Address:		City/Town:		State:	Zip:
DCF Social Worker:				Phone:	
DCF SW Supervisor:				Phone:	
Legal Status:			Legal Guardian:		
Parent/Guardian's Name:					
Placement Type:					
Placement Name:				Phone:	
Description of Placement:					
Caretakers Names:			Roles:		
School Name:				Grade:	
Does the youth have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:					
Is youth on any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:					
Mental Health Issues? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:					
Axis I Diagnosis and GAF (If available):					
Clinician's Name:				Phone:	
Expected living situation over the next twelve months:					
Brief assessment of the youth's ability and willingness to participate in the mentoring program. Describe and any identified, significant behavioral and/or health issues and/or concerns:					
Please describe the reason for an exception and why you feel this service would benefit youth :					
Has youth been informed of the Mentor Program? <input type="checkbox"/> Yes <input type="checkbox"/> No			Would the youth like a mentor? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the placement been informed of the Mentoring Program? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is the youth looking for in a mentor?					
<i>Note: Social Worker must attach a signed DCF-2131 "Release of Information" form to this referral.</i>					
Social Worker's Name:		Social Worker's Signature:		Date:	
Program Manager's Name:		Program Manager's Signature:		Date:	
When completed, please email this form to Dayna Snell for review and approval. Dayna.snell@ct.gov				Date:	
Approved by: Dayna R. Snell, One on One Mentoring Program Manager					