B.E.A.R.
Bitterroot Ecological
Awareness Resources, Inc.
1105 Main Street, Hamilton, MT 59840
(406) 363-5410
www.bearmt.org

REFERRAL FORM

Referral Source/Agency
Contact:_____Date:_____

Phone:_____ Email:_____

Youth's Name:_____ DOB:_____ Gender:_____

School:_____ Grade:_____

Contact Person for Youth:_____Phone:_____

Youth Lives With:_____

Race/Ethnicity: (circle all that apply) Caucasian, Hispanic, Asian, African American, Native American, other: _____

B.E.A.R. Inc. provides a variety of one-on-one and group mentoring services to youth ages 10-17 through our three programs: *Venture O.U.T., K.O.R.E., and Sk8 Montana*

Many factors are considered when enrollment is requested including: level of need, staff availability, and fit with program objectives. **Please note: Due to high demand, it is not unusual for there to be a waiting list.** B.E.A.R., Inc. does not discriminate against or act in favor of any employee, applicant, or program participant because of race, ethnicity, national origin, sex, religion, creed, marital or veteran's status, age, health, the presence of a disability, sexual orientation or any other basis prohibited by local, state, or federal laws. Program participants may contact Job Service through the Montana Department of Labor and Industry *wsd.dli.**mt**.gov/local/**hamilton**/* or call 363-1822 for guidance if they feel they have been discriminated against. Please note that necessary information included in this referral form may be shared to determine appropriate funding sources. Information shared will be limited to that needed to determine funding eligibility.

Reason for Referral: (Please check all that apply)

__Poor attendance or tardiness __ Substance abuse __Suicidal
__Disruption issues at school __ Inappropriate peer group __Seeking a mentor
__Academic challenges or failure __ Experienced trauma __Family issues
__Committed a violent/delinquent act __ Experienced mental health problems
__Lack of community involvement __Self harm

Please tell us about the youth's strengths. What do you and/or the youth hope to gain through participation in B.E.A.R.?

_____

_____

_____

_____

Has the family been informed about B.E.A.R. services? Yes ____No____

What is most important for us to know about the youth being referred?

_____

_____

_____

_____

Please mail referrals to B.E.A.R. c/o Val Aerni 1105 Main St. Hamilton, MT 59840 or email to val.aerni@bearmt.org.

_____

To Be Filled Out By Members of the Referral Review

Referral Review Members:

_____

☐ Referral Accepted Date: _____

☐ Place On Waiting List Date: _____

Reason:

_____

_____

_____