HOMESPACE
WORKING TO CHANGE TWO GENERATIONS AT A TIME

1030 Ellicott Street Buffalo NY 14209
(716) 881-4600 Fax: (716) 881-4604
www.homespacecorp.com

Young Parent Resource &Empowerment Program

Date of Referral: _____ **Case Number:** _____

CLIENT INFORMATION		
Name:	DOB:	Age:
Gender: Male Female	Pregnant? Yes No	Due Date: _____
Names/DOB of Children:		
Names/DOB of Children		
Currently in care? Yes No	Discharged from care? Yes No	
Ethnicity: Caucasian African American Asian Native American Other: _____		

CLIENT CONTACT INFORMATION	
Address:	City, State, Zip:
Home phone:	Cell phone:
Emergency Contact:	Emergency Contact phone:
Foster Parent(s) Name(s):	
Parent(s)/Guardian(s) Name(s):	
Other Contact:	Phone:
Other Contact:	Phone:
Other Contact:	Phone:
Other Contact:	Phone:

INFORMATION ON THE PERSON REFERRING		
Voluntary Agency:	School:	Other:
ECDSS Caseworker:	Phone:	

BACKGROUND INFORMATION
IEP: Yes No
Reason for referral:
Identify Independent Living Goals the youth needs help achieving: 1. 2. 3. 4.
Describe current living situation/household:

Reviewed by:	Date:

Young Parent Resource & Empowerment Program (Y-PREP)