NASSAU COUNTY YOUTH BOARD JUVENILE JUSTICE INITIATIVE

CLIENT TERMINATION

PLEASE COMPLETE ALL BOXES

REPORT FOR DATE ENDING: (YYYY-MM-DD)	
FCA REACH FP FP	○ WCIC○ YES○ GCBG
B: AGENCY CLIENT CODE:	
C: INITIALS OF CLIENT:	
D: INTAKE DATE: (YYYY-MM-DD)	
E: TERMINATION DATE: (YYYY-MM-DD)	
F. REASON FOR TERMINATION (Che	eck all that apply):
1. MOVED FROM SERVICE 2. ENROLLED IN JOB COR 3. TRANSFERRED TO OTH 4. AGED OUT OF PROGRA 5. ARRESTED/INCARCERA 6. JOINED ARMED FORCE 7. CLIENT REFUSED SERV	RPS HER PROGRAM: AM ATED/PLACEMENT FACILITY ES
8. SUCCESSFUL COMPLE 9. OTHER (SPECIFY):	TION OF PROGRAM

1. VOCATIONAL EDUCATION 2. RUNAWAY/HOMELESS SERVICES 3. G.E.D. PROGRAM 4. MENTAL HEALTH SERVICES 5. JOB READINESS TRAINING 6. LEGAL SERVICES 7. FAMILY MEDIATION PROGRAM 8. HEALTH SERVICES 9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY):	G. PLEASE INDICATE REFERRAL LINKS:		
3. G.E.D. PROGRAM 4. MENTAL HEALTH SERVICES 5. JOB READINESS TRAINING 6. LEGAL SERVICES 7. FAMILY MEDIATION PROGRAM 8. HEALTH SERVICES 9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY):		1. VOCATIONAL EDUCATION	
4. MENTAL HEALTH SERVICES 5. JOB READINESS TRAINING 6. LEGAL SERVICES 7. FAMILY MEDIATION PROGRAM 8. HEALTH SERVICES 9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY):		2. RUNAWAY/HOMELESS SERVICES	
5. JOB READINESS TRAINING 6. LEGAL SERVICES 7. FAMILY MEDIATION PROGRAM 8. HEALTH SERVICES 9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY):		3. G.E.D. PROGRAM	
6. LEGAL SERVICES 7. FAMILY MEDIATION PROGRAM 8. HEALTH SERVICES 9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY):		4. MENTAL HEALTH SERVICES	
7. FAMILY MEDIATION PROGRAM 8. HEALTH SERVICES 9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY): SIGNATURE OF PERSON COMPLETING THIS REPORT:		5. JOB READINESS TRAINING	
8. HEALTH SERVICES 9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY): SIGNATURE OF PERSON COMPLETING THIS REPORT:		6. LEGAL SERVICES	
9. EDUCATIONAL PROGRAM 10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY): SIGNATURE OF PERSON COMPLETING THIS REPORT:		7. FAMILY MEDIATION PROGRAM	
10. DEPARTMENT OF SOCIAL SERVICES 11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY): SIGNATURE OF PERSON COMPLETING THIS REPORT:		8. HEALTH SERVICES	
11. DRUG/ALCOHOL PROGRAM 12. OTHER (SPECIFY): SIGNATURE OF PERSON COMPLETING THIS REPORT:		9. EDUCATIONAL PROGRAM	
12. OTHER (SPECIFY): SIGNATURE OF PERSON COMPLETING THIS REPORT:		10. DEPARTMENT OF SOCIAL SERVICES	
SIGNATURE OF PERSON COMPLETING THIS REPORT:		11. DRUG/ALCOHOL PROGRAM	
		12. OTHER (SPECIFY):	
DATED COMPLETED: (YYYY-MM-DD)	SIGNATURE OF PERSON COMPLETING THIS REPORT:		
DATED COMPLETED: (YYYY-MM-DD)			
	DATED COMPLETED: (YYYY-MM-DD)		

*CLIENT TERMINATION FORMS SHOULD BE SUBMITTED MONTHLY, NO LATER THAN THE 15TH OF