



## Post Majority Support Services Referral Form

*The Post Majority Support Services is a voluntary service for youth/young adults requesting support. All information is held confidentially. We will work with youth/young adults to meet the goals they are working towards. Youth/young adults requesting support may provide a self-referral.*

*\*Youth (14-17) or young adults (18-25) **must** fit in one of the following to qualify for Post Majority Support Services. Please check all that may apply during the youths' lifetime. Must be an NFN member.*

- ☐ Extended society care (society ward)   ☐ Guardianship   ☐ Custody  
☐ Alternate care   ☐ Kinship care   ☐ VYSA

**First Name:**

**Last Name:**

**Address:**

**Status Card #:**

**DOB:**

**Identifies As:**

*At least one method of contact is needed.*

**Home Number:**

**Cell Number:**

**Email:**

### Household members Information

Name	Age	Relationship	Band Number

### Goals:

- ☐ Income   ☐ Adult Education   ☐ Family Relations  
☐ Employment   ☐ Legal   ☐ Mobility  
☐ Shelter   ☐ Health Care   ☐ Community Involvement

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Food                 | <input type="checkbox"/> Life Skills     | <input type="checkbox"/> Safety           |
| <input type="checkbox"/> Childcare            | <input type="checkbox"/> Mental Health   | <input type="checkbox"/> Parenting Skills |
| <input type="checkbox"/> Children's Education | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> ID               |

**How often would you like to meet?**

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**While working through goals, which check-in method would you prefer?**

- ☐ In person      ☐ Text      ☐ Phone Call      ☐ Email

**Are there any barriers to receiving services?**

- ☐ Yes, please explain

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- ☐ No

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## **REFERRAL INFORMATION**

**Name of Person Referring**

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**Contact  
Information**

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**NFN Department and Position (if applicable)**

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**Date of the Referral**

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