



STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

AD-XXXX-XX
New 1-1-2014

Exhibit 3
CITATION COMMUNITY SERVICE PROGRAM SERVICE AUTHORIZATION FORM (SAF)

I. REQUESTOR/REFERRAL SOURCE						
<u>Date of the Request:</u>		<u>Requestor Name:</u>			<u>Circuit:</u>	
<u>Contact Person:</u>			<u>Email Address:</u>			
<u>Telephone Number:</u>			<u>Fax Number:</u>			
II. YOUTH/PARENT/GUARDIAN INFORMATION-If this SAF is for a group approval Circle Y and proceed to last page						
<u>Youth's Name:</u>			<u>Parent/Guardian's Name:</u>			
<u>Youth Alias:</u>			<u>Relationship:</u>			
<u>Youth's Assessed Risk Level:</u>			<u>Address:</u>			
<u>Circuit:</u> Choose an Item			<u>County:</u>			
<u>Telephone # (home):</u>			<u>Telephone # (mobile):</u>			
III. YOUTH ELIGIBILITY REVIEW						
Did a certified law enforcement officer issue a Civil Citation to the youth?						
Was a copy of the Civil Citation forwarded to the Department's Circuit Probation Office or the Operating Entity						
Did the Civil Citation include sanctions issued by the issuing law enforcement officer? If so, please list.						
Did a review of JJIS confirm the youth is eligible for civil citation? Is the alleged offense a misdemeanor offense?						
Has the State Attorney consented to the youth's referral to a Civil Citation Community Service Program?						
Has the youth's parent(s)/guardian(s) provided his/her consent to participate in the Civil Citation Program?						
Does the youth have a mental health/substance need/offense requiring mental health/substance abuse services? <input type="checkbox"/> Yes (STOP and complete <i>Mental Health Screening Referring Form</i> and follow Residential Services procedures.) <input type="checkbox"/> No (Continue)						
IV. YOUTH ASSESSED NEEDS						
Type of Needs Assessment administered <input type="checkbox"/> PAT <input type="checkbox"/> Other What are the service needs identified on the PAT/Needs Assessment?						
V. REQUEST FOR SERVICES						
Contract #	Description of Service	Anticipated Begin Date	Anticipated End Date	County of Service	Rate	Estimated \$
Total						
PROBATION REVIEW - (To be completed by Probation and Community Intervention HQ)						



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I. YOUTH ELIGIBILITY

Is the youth eligible for the services requested based on (Check the appropriate box.):

Youth meets stated age requirements for services? : Yes No

Youth meets parameters regarding the youth's offense status? Yes No

Youth meets the eligibility requirements for the specific services requested? Yes No

II. FUNDING AVAILABLE

Is the youth eligible for the services requested based on (Check the appropriate box.):

Youth resides in a county offering the services requested? Yes No

Youth meets the eligibility requirements associated with the Program? Yes No

III. PROVIDER TO PROVIDE SERVICES TO YOUTH

Contract/Rate Agreement #:

Contact Person Telephone Number:

Provider Name:

Provider Name:

Contact Person:

Contact Person Telephone Number:

Contact Person:

Contact Person Telephone Number:

APPROVAL

Date of the Service Authorization Form Review:

Results of the SAF Review: SAF Request Approved SAF Request Denied (provide reason)

(Check the appropriate box.) If denied please provide reason:

Signature: _____

Print Name: _____

Title: _____

Date: _____ Phone: _____