# AGENCY REFERRAL FORM

## 1. Referring Agency

☐ **Domestic Violence Provider Agency** **Specify:**

☐ **Prison /Jail** **Specify:**

☐ **Other** **Specify:**

_____ _____

***Name of person referring client to InStepp*** ***Title***

_____ _____

***Phone Number*** ***E-mail Address***

## 2. Client Identification

Legal Name

Birthdate Age

Race ☐ White ☐ African American ☐ Asian ☐ Hispanic/Latino ☐ Other

Address Day Phone

_____

***At least one of the following criteria must be met in order for this individual to be enrolled***

1. Is individual a survivor of domestic violence AND is currently receiving support from a domestic violence service provider ☐ YES ☐ NO

2. Has individual lost the income of someone they were financially dependent on OR is receiving public assistance and is within two years of losing that public assistance? ☐ YES ☐ NO

3. Is client currently incarcerated and within six months of release from prison/jail OR was released from prison/jail within the past 12 months? ☐ YES ☐ NO

   If currently incarcerated, projected date of release: _____

## 3. Inclusion/Exclusion Criteria

***The answer to each question below must be YES***

1. Is individual female, at least 18 years of age? ☐ YES ☐ NO
2. Is client a resident of the Triangle area? ☐ YES ☐ NO
3. Is client unemployed or underemployed? ☐ YES ☐ NO

***The answer to each question below must be NO***

1. Has client been using drugs in past 6 months? ☐ YES ☐ NO
2. Does client have a history or current diagnosis of severe mental illness? ☐ YES ☐ NO
3. Does client have a past or current conviction for a **violent** offense unrelated to domestic violence? ☐ YES ☐ NO

**Please return this form via fax to 1.866.388.7409**

Revised January 2015