# AGENCY REFERRAL FORM

## 1. Referring Agency

- [ ] Domestic Violence Provider Agency  Specify: 
- [ ] Prison /Jail  Specify: 
- [ ] Other  Specify: 

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Name of person referring client to InStepp Title

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Phone Number E-mail Address

## 2. Client Identification

<table>
<thead>
<tr>
<th>Legal Name</th>
<th>Birthdate</th>
<th>Race</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Age

- [ ] White
- [ ] African American
- [ ] Asian
- [ ] Hispanic/Latino
- [ ] Other

Day Phone

## 3. Inclusion/Exclusion Criteria

*The answer to each question below must be YES*

1. Is individual female, at least 18 years of age?  
2. Is client a resident of the Triangle area?  
3. Is client unemployed or underemployed?

*The answer to each question below must be NO*

1. Has client been using drugs in past 6 months?  
2. Does client have a history or current diagnosis of severe mental illness?  
3. Does client have a past or current conviction for a violent offense unrelated to domestic violence?

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Please return this form via fax to 1.866.388.7409

Revised January 2015