Victims Assistance Center of Jefferson County, Inc.
Child Advocacy Center of Northern New York
Safe Harbour Program

Referral Form

Date of Referral: Click here to enter a date.
Referring Person: Click here to enter text.
Agency: Click here to enter text.
County: Choose an item.

Reason for referral:

☐ Case Tracking	☐ Internet Safety Course	☐ Clothing & Goods
☐ Advocacy	☐ Mental Health Referrals	☐ Emergency Shelter
☐ Financial Assistance	☐ Other Community Referrals	☐ Medical Exam

Child's Information:

Name:	**Preferred Name:**	**DOB:**
Biological Sex:	**Gender Identity:**	**Pronouns:**
Sexual Orientation:	**Race/Ethnicity:**	**Language Spoken:**
Phone:	**Address:**	
Last Grade Completed:	**Pregnant or Nursing:**	
Accommodation Needed: Yes ☐ No ☐	*If yes, explain:*	

Caregiver Information:

Name:	**Relationship:**
DOB:	**Phone:**
Address:	**Safe to Contact: ☐ Yes ☐ No**

Background Information:

Services Already in Place:

Type of Service	Service Location	Provider Name

Is CPS involved?:

Current: Yes ☐ No ☐
Case worker name:

Past: Yes ☐ No ☐
Case worker name:
How did the assessment close?

Is Law Enforcement involved? :

Current: Yes ☐ No ☐
Investigator Assigned:
LE case number:

Past: Yes ☐ No ☐
Agency:

Alleged Suspect Information: ☐ Unknown ☐ N/A

Name:
Other Known names:
DOB: **Race:** Choose an item.
Relationship: Choose an item. **Gender:** Choose an item.
Address: Choose an item. **Military Affiliation:** Choose an item.