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

REFERRAL FORM

Date of Referral:
Referring Person:
Contact Phone#/Email:
Agency:
County:

Reason for referral:

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

Child's Information:

Name: **Preferred Name:** **DOB:**
Biological Sex: **Gender Identity:** **Pronouns:**
Sexual Orientation: **Race/Ethnicity:** **Language Spoken:**
Phone: **Address:**
School District: **Last Grade Completed:**
Pregnant: Yes ☐ No ☐ **Nursing:** Yes ☐ No ☐
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:**
Relationship: **Gender:**
Address: **Military Affiliation:**