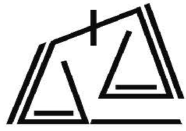

VICTIM ADVOCATE PROGRAM

REFFERAL

Agency Referring:	Name:
Direct Contact:	Title:
Person Being Referred:	Contact:
Secondary Contact:	Address:
Are they in crisis? ☐ Yes ☐ No	Are they aware of referral? (minor) ☐ Yes ☐ No
Are they needing shelter? ☐ Yes ☐ No	Do they have children with them? ☐ Yes ☐ No
Are they a victim of crime? ☐ Yes ☐ No Type: ______________________________	Do they have any disabilities? ☐ Deaf/ hard of hearing ☐ Blind/ low vision ☐ Physical ☐ Mental
Check supports requesting: ☐ Immediate Shelter ☐ Crisis Intervention ☐ Criminal Justice Information ☐ Criminal/ Civil Justice Legal Assistance ☐ AOD Services ☐ Emotional Support/ Safety Services ☐ Intimate Partner Violence Education/Intervention ☐ Behavioral Health Assistance	Additional Comments:

Please submit via email to:
Hoopacourt.advocate@gmail.com Or Call
(530)625-4305 ext. 309

www.hoopacourt.com

Advocate Agency Use Only

Date Received:	Case #:	
Date Assigned:	Director:	Assigned Advocate: