

Legal Advocacy Project Client Referral



REFERRER INFORMATION:

DATE: _____

NAME: _____

REFERRING AGENCY: _____

E-MAIL: _____

AGENCY PHONE NUMBER: _____

TYPE OF CASE(S):

(check all that apply)

Divorce
Child Custody/ Visitation
Paternity
Restraining Order
Child/ Spousal Support
Other: _____

U-Visa
VAWA
T-VISA
Permanent Residency
Naturalization
TPS
DACA

TYPE OF ABUSE:

Domestic Violence
Sexual Assault
Stalking
Other: _____

SURVIVOR INFORMATION:

NAME: _____

DOB: _____

Safe number to call: _____

Okay to leave voicemail? Yes No

When is best day/time to call the client M T W TH F around _____ :00 a.m./ p.m.

Language Preference: _____

ADVERSE PARTY INFORMATION:

DOB: _____

NAME: _____

Relationship to client: _____ (i.e. spouse, dating relationship)

ANY OTHER RELEVANT INFORMATION?

Please email this referral form to lizeth@peaceoverviolence.org filled out completely as possible. Potential client will be contacted within 72 hours by our staff members.