



*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

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:

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:

Relationship: Choose an item.

Address: Choose an item.

**Race:** Choose an item.

**Gender:** Choose an item.

**Military Affiliation:** Choose an item.