DHR SAIL PROJECT REFERRAL

Referral Source: **JOBS_____ Child Support_____ Family Services_____**
Food Assistance_____ ACADV_____ Adult Protective Services_____

Case Name: _____ Case Number: _____
Address: _____ Client SSN: _____
_____ Phone: _____
_____

List a phone number or address that is safe for client contact: _____
_____

Referral Reason: _____
_____

Is client receiving FA_____ FS_____ Medicaid for Low Income Families (MLIF)_____

If not receiving one of the above, what is the gross monthly income? _____

Case Manager/DHR Worker: _____ Date: _____
Phone: _____ Program: _____
Response requested: Yes_____ No _____ (**Note:** Required if JOBS Referral)

I give permission for DHR to release information to the DV specialist and/or shelter about my situation related to this referral and to the receipt of domestic violence services.

Client signature: _____ Date: _____

SAIL Use Only: **SAIL Project_____ Other ACADV Program_____ No Services_____**

IS THE CLIENT IN IMMINENT DANGER OR THREAT THEREOF? YES____ NO____

SOS Plan Initiated? Yes_____ Date: _____

No _____ Reason: _____
Comments: _____
_____
_____
SAIL Specialist: _____ Date: _____ Phone: _____
Response sent to: JOBS_____ CS_____ Family Services_____ FA_____ APS_____

DHR-FAD-2081 (Revised 9/17/10)