WCYFS INTERAGENCY REFERRAL PROCESS

When to use this form:

- You are a representative of an agency that works with people who may have experienced sexual assault, domestic violence, human trafficking, or are homeless/runaway/at-risk youth.
- The person you are working with is aware of and interested in the services Women's Center-Youth & Family Services (WCYFS) offers.
- The person you are working with wants a WCYFS staff member to reach out to them to discuss service provision and set up ongoing services.
- This referral form does not take the place of existing referral processes such as seen in our Safety Net program, or response protocol for SART.

How to fill out this form:

1. Fill out client information for the primary individual seeking services.
2. If the client would like services for their children, please fill out the name and date of birth for all children that will be receiving services.
3. Check mark all applicable "PRESENTING CONCERNS/NEEDS"
4. Please read the "CONSENT TO RELEASE INFORMATION" statement with the client.
5. Client initials and signs the form
    a. If the client is 12 years old and older, that person must sign
    b. If the client is requesting services for children under 12 years old, the parent/guardian must sign.
6. The "REFERRING AGENCY" refers to the agency that is filling out this form
7. Fill out the "REFERRED BY" area of the form with your contact information.
8. If you are referring the client to a specific department or known WCYFS employee, fill out the "REFERRED TO" area; otherwise you can leave this area blank.
9. To send form in:
    a. Drop off in person
    b. Via encrypted (password protected) email to a WCYFS employee, or to referrals@wcyfs.org
    c. Via fax to: (209) 941-4963
    d. Via regular mail to:
        i. WCYFS
        620 North San Joaquin Street
        Stockton, CA 95202

*****WCYFS STAFF WILL ATTEMPT TO MAKE CONTACT WITH CLIENTS WITHIN 3 BUSINESS DAYS FROM THE RECEIPT OF THIS REFERRAL**

Date of Referral: _____

WCYFS INTERAGENCY PROGRAM REFERRAL

CLIENT CONTACT INFORMATION:

Name: _____ DOB: _____

Primary Language: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other _____

Phone: _____ Safe to Leave a Message? ☐ Yes ☐ No

LIST CHILDREN THAT WILL BE RECEIVING SERVICES

Name	DOB

PRESENTING CONCERNS/NEEDS:

☐ Sexual Abuse/Assault	☐ At-risk youth/TAY	☐ Anger/violence
☐ Domestic Violence	☐ Skillful Parenting	☐ Abuse/neglect
☐ Shelter	☐ Co-Parenting	☐ Substance use
☐ TRO	☐ Depression/Anxiety	☐ Behavioral problems
☐ Human Trafficking	☐ Suicidal	☐ Other (please describe)

_____

CONSENT TO RELEASE REFERRAL INFORMATION *(read with client and answer any questions before the client signs below)*

I, _____(concerned individual initials), understand that the purpose of the referral and of disclosing this information to the **Women's Center-Youth & Family Services (WCYFS)** is to ensure the safety and continuity of care among service providers seeking to serve this individual/family.
The service provider, _____(referring agency), has clearly explained the referral process to me, that **WCYFS** will be contacted, and the above information will be disclosed.

****IF CLIENT SEEKING SERVICES IS 12 YEARS OLD OR OLDER, THEY MUST SIGN THIS RELEASE.****
IF SEEKING SERVICES FOR PERSONS UNDER 12 YEARS OLD, A PARENT/GUARDIAN MUST SIGN.

By signing this form, I authorize the release of the above information and request that a WCYFS staff member make contact with me.

Date: _____ Signature: _____

Referred by:	Referred to:
Name:	Name:
Position:	Position:
Agency:	Agency:
Contact Info:	Contact Info:

Delivered via: ☐ E-mail (encrypted) ☐ In-person (sealed envelope)
☐ Mail ☐ Fax (209) 941-4963

WCYFS STAFF WILL ATTEMPT TO MAKE CONTACT WITH CLIENTS WITHIN 3 BUSINESS DAYS FROM THE RECEIPT OF THIS REFERRAL. IF NO CONTACT IS MADE, CLIENT MAY CALL **(209) 941-2611**.