

DATE: _____

DISCLAIMER

This project was supported by Grant No. 2017-WL-AX-0022 awarded by the Office on Violence against Women, US Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence against Women.

Email the completed form to:
ksopcich@mocsa.org

MOCSA LAV REFERRAL

**Required Information for consultation-only referrals*

APPLICANT'S INFORMATION (Victim of Sexual Assault must be 11 years or older)

Non-Intimate Partner Sexual Assault

Intimate Partner Sexual Assault

*Last Name: _____ *First Name: _____ Middle Initial _____

DOB: _____ *Phone Number: _____ Email: _____

*VM OK? YES NO *OK to identify as MOCSA? YES NO Best times to call: _____

Safe Mailing Address: _____

Gender: M F Other: _____ Race: _____ Marital Status: _____

*LEP: YES NO If yes, preferred language _____

Special Accommodation? : YES NO If yes, specify _____

*Legal Guardian (for victims age 11-17): _____ *Phone Number: _____

Names and Ages of Victim's Children involved: _____

*Is applicant working with another attorney in this or a different case? YES NO

If yes, name: _____

Name of Opposing Party: _____ DOB of Opposing Party (If known): _____

Does opposing party have an attorney? (If known) YES NO

If yes, name: _____

***REASON FOR REFERRAL**

Adult Order of Protection

Child Order of Protection

Paternity/Custody Case

Dissolution of Marriage

Modification of Custody/ Dissolution

Immigration

Title IX

Consultation/Victim Rights

Other (specify): _____

COURT CASE INFORMATION

Is there any court case pending? YES NO Case Number (if known): _____

Court Date: _____ Location: _____

MOCSA Legal Assistance Staff Use Only:

Name of Referring Agency/Staff Member: _____

Type of Referring Agency: Advocacy Counseling Shelter Legal Svcs/Attorney Other: _____

Phone Number: _____ E-mail: _____