

**BATTER INTERVENTION PROGRAM REFERRAL**

**Date** Click here to enter text.

**Name of Client** Click here to enter text.

**Social Security Number** Click here to enter text.

**Date of Birth** Click here to enter text.

**Mobile** Click here to enter text.

**Address** Click here to enter text.

**Name of Referring Person Click here to enter text.**

**Email Click here to enter text.**

**Mobile Click here to enter text.Direct Line Click here to enter text.**

**Address Click here to enter text.**

**Referring Source:**

[ ]  Court

[ ]  Probation Officer

[ ]  Attorney

[ ]  DCF

[ ]  Other Please List Click here to enter text.

**Referring County:**

[ ]  Cherokee

[ ]  Crawford

[ ]  Labette

**Status of Client**[ ]  Employed

[ ]  Unemployed

[ ]  Disabled (client must show proof of SSI eligibility through determination letter or check)

**Service requested:**

[ ]  Kansas Domestic Violence Offender Assessment (KDVOA)

[ ]  24 week Batter Intervention Program (BIP)

(Please note SRMHW BIP only accepts those participants assessed as appropriate)

Court Ordered? [ ]  Yes [ ]  No

* Please attach a copy of the police report if applicable

Please sign, retain one copy for your records, and send referral to:

BIP@SRMHW.org