BATTER INTERVENTION PROGRAM REFERRAL

Date:

Name of Client:

Social Security Number:

Date of Birth:

Mobile:

Address:

Name of Referring Person:

Name of Referring Agency:

Email:

Mobile: Direct Line:

Referring Source:

[ ]  Court

[ ]  Probation Officer

[ ]  Attorney

[ ]  DCF

[ ]  Other Please List:

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:

bipgroup@srmhw.org