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