HOPE HARBOR, INC.:
A SEXUAL TRAUMA RECOVERY CENTER
EXTERNAL REFERRAL FOR SERVICES

LOCATION OF SERVICES

Please check the location to which you would like to make a referral:

☐ 913 Broadway Ave.
Bowling Green, KY 42010
Phone: 270.782.5014
Fax: 270.782.5042

☐ 1112 S Main St.
Suite 3
Franklin, KY 42134
(Call Bowling Green Office)

☐ 204 N Race Street
Glasgow, KY 42141
Phone: 270.629.4673

REFERRING AGENCY INFORMATION

Date: _____ Agency: _____

Phone: _____ Representative: _____

CLIENT CONTACT INFORMATION

Name of Client: _____ Street Address: _____

Age & Date of Birth: _____ City, State, Zip: _____

Legal Guardian: _____ County: _____

Contact person (if client is a child): _____

Contact Person's relationship to child: _____

Cell Phone: _____ ☐ Okay to leave message?

Home Phone: _____ ☐ Okay to leave message?

Former Hope Harbor Client
Yes _____ No _____

CASE TYPE

Please check all that apply.

CHILD VICTIM
- ☐ Rape
- ☐ Child Sexual Abuse/Incest
- ☐ Other:_____

ADULT VICTIM
- ☐ Rape
- ☐ Adult Molested as Child
- ☐ Other Sexual Assault

OTHER
- ☐ Non- Offending Parent
- ☐ Sibling of Victim
- ☐ Other: _____

**NO ASSESSMENTS OR INVESTIGATIONS OF SEXUAL ABUSE ARE CONDUCTED BY HOPE HARBOR, INC.

SERVICE(S) REQUESTED

Please check all that apply.

☐ Individual ☐ Group ☐ Couple ☐ Family ☐ Legal Advocacy

Language: _____ Disability/Accommodations: _____ RClient: _____

RELEASE OF INFORMATION

I agree to allow the above named referring agency to release this information to Hope Harbor, Inc. for therapeutic or legal advocacy services. My signature below indicates that I wish to have a representative from Hope Harbor, Inc. contact me to arrange services for myself and/or for my dependent child. I certify that I am legally responsible for myself and/or my dependent child. [IN CASES OF CHILD REFERRALS, DOCUMENTATION OF GUARDIANSHIP/ CUSTODY WILL BE REQUIRED TO INITIATE TREATMENT]. I further agree to allow a representative from the referring agency to contact Hope Harbor, Inc. to follow up on this referral to ensure that I have been contacted for services. I may terminate this release at any time I wish with a written statement to Hope Harbor, Inc. I understand that this authorization is VOLUNTARY and that I MAY REFUSE TO SIGN IT. I also understand that treatment from Hope Harbor, Inc. may not be denied if I refuse to sign this authorization. I may, at any time, contact Hope Harbor, Inc. directly to self-refer to available services.

This authorization will expire on: _____

_____ _____

Client/Guardian Signature Date Referring Agency Representative Date

Thank you for your referral. A representative from Hope Harbor, Inc. will respond as quickly as possible to collect and provide further information on available services.