Victim Support Services Referral Form

☐ Yes, I would like CCSO Victim Support Services (VSS) to connect our organization with DV victims/survivors.

Name of your Organization: ___________________

Intake phone line: ___________________

Please check the boxes of all the services your organization offers:

☐ Counseling/Therapy	☐ Crisis Intervention	☐ Education	☐ Emergency Housing
☐ Workforce Assistance	☐ Food Assistance	☐ Legal Assistance	☐ Immigration Services
☐ Medical Care	☐ Transportation	☐ Public Assistance	☐ Counseling/Adolescents

Other services offered: ___________________

Do you have a Certified Domestic Violence Professional (CDVP) on staff? ☐ Yes ☐ No

Do you have Sexual Assault Advocates on staff? ☐ Yes ☐ No

Name (Individual filling out form): ______________________________________ Date: __________

Contact information for someone from VSS to speak to about your organization?

Email: _______________________________

Phone number: _______________________________

***Please email completed referral form to CCSO.VictimSupportServices@ccsheriff.org**