

REFERRAL FORM

Date:

Has the referring agency verified sex trafficking history based on the human trafficking screening tool? Y/N

1. How long ago was the survivor actively exploited by her trafficker?
2. How long has it been since the survivor had contact with her trafficker?
3. Is the survivor currently pregnant or has dependent children? ☐ Yes ☐ No
   If so, what are the children's ages?
4. If the survivor's children are not under her supervision, who are they currently with?
   Can she provide legal documentation? ☐ Yes ☐ No Is she actively pursuing custody? ☐ Yes ☐ No
5. Does the survivor have any past or current outstanding legal issues that would need to be addressed and resolved? ☐ Yes ☐ No
   If yes, please explain:
6. Has the survivor completed any mental health or recovery programs? ☐ Yes ☐ No
   If yes, please list all the programs attended and/or competed:
7. Does the survivor have any serious medical or mental health diagnoses that would prevent her from actively participating in and pursuing continuing education, employment, and long-term sustainable housing? ☐ Yes ☐ No
   If yes, please explain:
8. Does the survivor have any violent criminal charges that would prevent her from actively participating in and pursuing employment, and long-term sustainable housing? ☐ Yes ☐ No
   If yes, please explain:
9. Does the survivor have any legal mandates that would prevent her from actively participating in and pursuing employment and long-term sustainable housing? ☐ Yes ☐ No
   If yes, please explain:
10. Has the survivor participated in any residential programs? ☐ Yes ☐ No
    Did she complete the program(s)? ☐ Yes ☐ No
    If so, how did she function in that environment?
11. How does the survivor interact in group and social settings and what did you (or other referring agencies) observe about her behavior? (Social, aggressive, passive, etc.)
12. What have been the greatest challenges for the survivor and the staff during their time at your agency?

13. Is the survivor currently on medical/mental health medications? ☐ Yes ☐ No
    If yes, please list medications and diagnoses:
    Is she willing to continue medical and mental health management consistently? ☐ Yes ☐ No
14. Are you aware of any paranoia, mania, or borderline personality tendencies? ☐ Yes ☐ No
    If yes, please explain
15. Has she had any extreme meltdowns or panic attacks during her stay at your agency? ☐ Yes ☐ No
    If yes, please explain:
16. Have there been any behaviors that you have noticed that do not line up with a current or prior mental health diagnosis? ☐ Yes ☐ No
    If yes, please explain:

*Please share any additional information that you feel would be pertinent to our evaluation in determining eligibility for Mother's Nest

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Additional Agency Information:

- Will the referring agency provide any further support for the survivor? If so, how much and how often?
- Are there any other resources needed and/or available to the survivor through the referring agency or partnering agencies?
- Is there any funding available for additional living expenses from the referring agency or partnering agencies?

Referring Agency Contact (person that completed the questionnaire): _____

Email: _____

Phone: _____