

TRAFFICKING VICTIM ASSISTANCE PROGRAM

REFERRAL FOR TVAP SERVICES

Please do not include any personal identifying information – any client names, phone numbers and addresses should be shared directly to the provider who has accepted the referral.

Referrer Information

Name:	<input type="text"/>	Date of Referral:	<input type="text"/>
Phone Number:	<input type="text"/>	Email:	<input type="text"/>
Organization:	<input type="text"/>		

Client Information

Client Initials:	<input type="text"/>	Gender:	<input type="text"/>
Client's DOB:	<input type="text"/>	Type of Trafficking:	<input type="text"/>
Client's current location (City, State): <input type="text"/>			
Does the client have any emergency needs? <input type="text"/>			
Does the client have their Interim Assistance/Eligibility or Certification Letter? Yes ☐ No ☐			
If yes, what is the HHS Tracking Number? <input type="text"/>			
Does the client require any translation services? Yes ☐ No ☐			
If yes, what language does the client speak? <input type="text"/>			

Comments (ex: services needed, intent to relocate):

**Submit completed form to traffickingvictims@uscridc.org.
If you prefer to coordinate via phone, please call TVAP at 1-800-307-4712.**

Important: The information provided on this form is confidential and intended solely for the use of making a referral to TVAP. TVAP will only share this form with service providers who may be able to accept the referral and assist the client.