Victim Services Incorporated

Advocacy * Education * Hope

REFERRAL FOR SERVICES

Client Name: _____ DOB: _____

Parent/Guardian (if applicable): _____

Home Address: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Preferred Number? *Home* *Cell* May we identify the agency by name at this number? *Yes* *No*

THERAPY ONLY

Primary Insurance Company: _____ Insurance ID Number: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

☐ Client would prefer his/her insurance not be billed for the service (this will not delay or prevent services)

REASON FOR REFERRAL: _____

_____

_____

_____

REFERRAL FOR (select all that apply):

- ☐ "My Body and Me" Program
- ☐ Supportive Counseling
- ☐ Trauma Therapy
- ☐ EMDR
- ☐ Support Group (sexual abuse)
- ☐ Support Group (homicide)
- ☐ Victims Compensation Assistance
- ☐ Non-Offending Parenting Group
- ☐ Court Preparation / Accompaniment
- ☐ Trauma Sensitive Yoga
- ☐ Other: _____

Referring Agency: _____

Address: _____

Contact Person: _____ Phone: (_____)_____

PLEASE FAX ALL REFERRALS TO OUR CAMBRIA COUNTY OFFICE AT (814) 288-3904

04/2018

CAMBRIA COUNTY
Administrative and Counseling Office
638 Ferndale Avenue / Johnstown, PA 15905
814-288-4961 Fax: 814-288-3904

SOMERSET COUNTY
Counseling Office
203 E. Patriot Street / Somerset, PA 15501
814-443-1555 Fax: 814-443-6807

www.victimservicesinc.org