

DOMESTIC ABUSE CENTER – Referral Form

P.O. Box 7194, Columbia, SC 29202 ■ Phone: 803-791-1322 ■ Fax: 803-791-0515

ATTN: Referral Sources: * = required items. Please fax and/or mail form to office. Phone referrals are accepted or call for an email address to send a scanned referral. Please contact DAC first to discuss if client needs special accommodation for disability or language. Thank you.

CLIENT/OFFENDER INFORMATION	VICTIM INFORMATION
*Name:	Name:
*Mailing Address (+Apt or Lot#)	Mailing Address (+Apt or Lot#)
*Phone (1) (2)	Phone:
*Date of Birth	Relationship:
Last 4 numbers of SSN #:	No Contact Order: Yes/No (circle one)
*Gender:	Order of Protection: Yes/No (circle one)
Warrant or Case Number:	

REFERRAL SOURCE INFORMATION

*Agency or Court or Office	
Contact Person	
*Phone	
Fax	
Email	

If Client is present, have them review, initial & sign acknowledgements:

___ I understand I am required to attend a **minimum** of 26 group sessions. **These 26 groups are separate from any intake/orientation session, assessment session, or exit interview.**

___ Fees are \$50 at first enrollment or intake/orientation session and \$30 at each of remaining sessions.

___ I will be contacted by DAC staff, by mail, regarding when and where to attend my first session and my exact fee payment details and methods of payment. I can call to verify my enrollment. Failure to start can result in a dismissal.

___ I am responsible for my own transportation to and from sessions.

Client's Signature: _____ **Date:** _____