Adoption and Guardianship
AGAPE
Assistance Program for Everyone

REFERRAL FORM

This form can be completed by staff or by the parent or guardian

Name of Primary Caregiver: _____

Address: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Type of family: ☐ Adoption ☐ Guardianship ☐ Pre-Adoptive

Primary Language: ☐ English ☐ Spanish

What is the best time to contact? _____

☐ There is an immediate need or concern

☐ There is no immediate need or concern, but please add me/parent to AGAPE's distribution list

If there is an immediate need or concern, please describe:

_____

_____

_____

_____

If self-referral:

Signature: _____ Date: _____

If agency referral:

Staff Person Name: _____

Agency: _____

Phone: _____ Email: _____

Do you want us to contact you before contacting the primary caregiver? ☐ Yes ☐ No

Please fax form to 888.482.9112 or scan and email to agape@affcny.org
Alternatively, agencies may contact AFFCNY to arrange for pick up of forms