



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 845.633.8041 or scan and email to agape@affcny.org
Alternatively, agencies may contact AFFCNY to arrange for pick up of forms

