



Survivors Pathway Corporation

Justice and Empowerment Center

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REFERRAL

Date: _____ Client/Victim's Preferred Language: _____

Client/Victim's Name: _____ Preferred Name: _____

D.O.B: _____ Phone Number: _____ E-mail: _____

Referring Agency: _____ Person Referring: _____

Phone: _____ E-mail: _____

Crime Reported to _____ Police Department or DCF/FBI/Other _____

Police Report Number/SAO Case Number: _____ Attached: Yes ___ No ___
Please attach Police Report if Applicable

Has Victim Compensation been filed? Yes ___ No ___ VC Claim Number if known: _____

Special Accommodations: Yes ___ No ___ Describe: _____

Service Delivery: Home ___ Survivors Pathway Office ___ Other: _____

Indicate Services Below

Mental Health Program

Domestic Violence Victim
Sexual Assault Victim
Minor Witnesses of Domestic
Violence/Sexual Assault
Human Trafficking Victim
Violent Crime Victim
Homicide Survivors
Biopsychosocial Assessment

Public Health Program

Survivor Trauma Informed
Support Group for Domestic
Violence in Spanish
Trauma Informed Support Group to
the Transgender Community in
Spanish
Trauma Informed Support Group to
the LGBTQI Community
HIV Testing, Counseling & PrEP
Referral to Medical care

Advocacy Program

Criminal Justice Support &
Advocacy/Court accompaniment
Filing for VC Benefits
Legal Assistance Referrals
Case Management for HT victims
Immigration Referrals for victims
Food Assistance

Other: