PUBLIC LAW CENTER

PROVIDING ACCESS TO JUSTICE
FOR ORANGE COUNTY'S LOW INCOME RESIDENTS

AIDS Legal Assistance Project (ALAP) Referral

Phone: (714) 541-1010 x 273, 210 (Spanish) Fax: (714) 541-5157

Today's Date: _____

Client Name (print): _____

DOB: _____

Address: _____

City: _____ ZIP Code: _____

Client's Preferred Phone: ( ) _____ Call OK? Yes / No Discretion? Yes / No

THE FOLLOWING CRITERIA MUST BE MET IN ORDER FOR THE REFERRAL TO BE ACCEPTED:

I, as the person making this referral, have ensured that eligibility and financial assessment have been conducted and all required documents are present and filed in the eligibility section of the client file at the referring agency.

Person/Agency Referring

_____ _____

Name of Person Making Referral (Print) Title

_____ _____

Signature of Person Making Referral Date

Referring Agency (circle one): HCA Clinic LBCC ASF REACH Delhi Shanti

The Center AltaMed Straight Talk APAIT Other

Referring Agency's Contact and Phone: ( ) _____