



CINS/FINS Referral Form for AAL Legal Representation

Please email completed form to scott@crossroadsfloridakids.org

Date:	Date Sheltered:	
Name of Prospective Client:		
Gender:	Date of Birth:	Phone #:
Case Number(s):		
Current Residence (Name/Address):		
Next Hearing Date:		

Parties/Participants:

Name of Father :	Counsel for Father :
Name of Mother :	Counsel for Mother :
Name of GAL assigned:	
Phone:	Email:
Name of CLS Attorney assigned:	
Name of Caregiver :	
Phone:	Email:
Name of Case Manager :	
Phone:	Email:
Name(s), Age(s) of Sibling(s):	

LEGAL NEEDS/SPECIAL CIRCUMSTANCES (Check any that apply)

<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Intellectual Disability/Autism
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Human Trafficking
<input type="checkbox"/> Counseling Needs	<input type="checkbox"/> Transportation Needs
<input type="checkbox"/> Education/School Needs	<input type="checkbox"/> Medical Benefits/Needs
<input type="checkbox"/> Additional Information: _____	

Circuit Judge or General Magistrate, Juvenile Dependency
Thirteenth Judicial Circuit

Note: Referral Information is required for conflict checking purposes