



Catholic Charities of the Diocese of Charleston, Inc.

Serving God's family throughout South Carolina.

Agency Referral Form

Please complete form and fax or email to your regional Catholic Charities office. All sections and items on this form are required to be considered a complete referral. Any forms not completed in their entirety will not be reviewed.

Referring Agency Information

Referring Agency: _____	Date: _____
Caseworker Name: _____	Title: _____
Phone Number: _____	Email: _____
Fax: _____	

Requested Assistance Details

- | | | |
|--|---|---|
| <input type="checkbox"/> Pregnancy Case Management | <input type="checkbox"/> Save A Smile (Dentures) | <input type="checkbox"/> Outreach Services/Special Events: Back To School, Thanksgiving, Christmas. |
| <input type="checkbox"/> Disaster Case Management | <input type="checkbox"/> Wellness Program (SNAP Enrollment) | |

Referred Client Information

Do they have an open case file with your agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do they have an assigned case manager with your agency, coordinating services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Date of Birth: _____
County: _____	Phone Number: _____
# Adults: _____	# Children: _____

Case Description

Please note assistance is subject to availability of funds and current caseloads. A referral does not automatically guarantee assistance. Catholic Charities will follow up with clients and agencies within in 2 business days regarding their referral.