Montana Coalition
Against Domestic & Sexual Violence

Sexual Assault Legal Services Program (SALS)

REFERRAL FOR LEGAL SERVICES

Applicant Name: _____ DOB: _____

Parent / Guardian's Name (If Applicant is under 18): _____

Former/Other Names: _____

Gender Identity: _____ Pronouns Used: _____

Race/Ethnicity: _____ Preferred Language: _____

If needed, list translation services you may need: _____

Other accommodations needed: _____

Mailing Address: _____ City: _____ Zip: _____

Who else has access to your mailbox?: _____

May SALS send you confidential mail at this address? _____

Phone number(s) for a callback from SALS: _____ The best time to call? _____

Is it safe to leave a confidential voicemail message? _____

Email address: _____

Can you receive confidential emails at this address? _____

*The SALS program must have information about your safe mail/email/voicemail in order to communicate with you about your application. *

LEGAL NEEDS / QUESTIONS

Referring Agency (if any): _____

Advocate Name/Phone Number (if any): _____

Please describe the legal issue with which you need assistance:

_____

_____

Have any court papers been filed related to your legal issue(s)? _____

Filed when: _____ Type of document filed: _____
Filed by you or the opposing party? _____

Have you filed for an Order of Protection (Restraining Order)? _____

If so, what is/was the date, time, and location of the hearing? _____

Any other court deadlines pertaining to your legal issue(s)? _____

OPPOSING PARTY / ABUSER

Name(s): _____ Age: _____

Former / Other Names: _____

Last Known Address / Location: _____

Is this person represented by an attorney? _____ If yes, attorney name: _____

Do you have children with this person? _____

Names and Ages of Children: _____

What type of relationship are/were you in with the opposing party?

_____dating
_____marriage (married since ____year)
_____cohabitation
_____acquaintance/friend
_____no relationship

DATE APPLICATION SENT TO SALS: _____

Thank you for your interest in the Sexual Assault Legal Services Program. **If you are an advocate applying on the client's behalf, please complete a release form** to accompany this application and send to:

MCADSV Sexual Assault Legal Services Program
P.O. Box 818
Helena, MT 59624

Or, email to: rclouse@mcadsv.com
Or, fax to: 406-403-0499

You will receive confirmation that your application was received. Please follow up with your application if you are **not** notified of receipt. After your application is received it will be processed and a member of the SALS legal team will contact you no later than seven business days from the date SALS receives the referral. Please call (406) 443-7794 x 113 with questions.

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