LOS ANGELES COUNTY JUSTICE CARE AND OPPORTUNITIES DEPARTMENT

Rev. 4/7/2026

DOORS AV Community Referral Form/Self-Referral Form

Please send the completed form via email to doors-av-referrals@jcod.lacounty.gov

Reset Form

Referral Source (Check one)

◯ Walk-In/Self Referral ◯ Internal (CBO) ◯ External CBO

First Name	Mid Name

Last Name

Phone:

Email:

Date of Birth:	SSN: (last 4 digits)

Address (No., Direction, Street, Type, Apt/Ste, City, State) or "homeless"	Zip Code

Race/Ethnicity (indicate all that apply):

☐ Hispanic/ Latinx
☐ African American
☐ Asian
☐ White
☐ Bi-Racial
☐ Middle Eastern/North African
☐ Native Hawaiian, Guamanian, Samoan, Tongan, Other
☐ Other Identified ethnicity or race

Gender:

◯ M ◯ F ◯ Trans Woman (MTF) ◯ Other
◯ Nonbinary ◯ Trans Man (FTM) ◯ Prefer Not To Answer
◯ Prefer To Self Define _____

Highest Education Level: _____

Has a Valid CA Drivers Lic. ◯ Yes ◯ No _____

Has a Valid CA ID ◯ Yes ◯ No _____

Employment Status: ◯ FT ◯ PT ◯ Unemployed

Veteran: Served one (1) day or more in the US Military?

◯ Yes ◯ No ◯ Prefer Not To Answer ◯ Unknown

Is veteran currently Service Connected? ◯ Yes ◯ No

Probation/Parole

Prior Arrests: ◯ Yes ◯ No ◯ Unknown

Prior Convictions: ◯ Yes ◯ No ◯ Unknown

☐ Adult ☐ Juvenile X or CDR number:

Probation Referral Office (Only Complete if on Active Probation)

Are you on Probation or Parole? ◯ Yes ◯ No

If yes, please indicate which probation/parole office you report to: (write in)

Service(s) Requested (Mark All that Apply)

ACTA
☐ Art Therapy

ACT
☐ Employment Support

NLSLA
☐ Legal Aid

Five Keys EDU
☐ High School/GED

TimeList
(Not Court Mandated)
☐ Family Reunification
☐ Child Support Services
☐ Family Law
☐ Anger Management
☐ Domestic Violence
☐ Support Group:
☐ Women ☐ Parenting
☐ Men ☐ Reentry

Five Keys Self-Help
(Court Mandated)
☐ Anger Management
☐ Domestic Violence
(Check one below)
◯ Offender ◯ Survivor
☐ Parenting Class

MVA
☐ Veteran Services

JCM
☐ Intensive Case Management

Catalyst
☐ Move In Assistance
☐ Utility Assistance
☐ Rental Arrears
Amount: _____

Benefits: ☐ GR ☐ Medical ☐ Cal Fresh ☐ SSI/SSDI

Mental Health: ☐ Behavior Management ☐ Medical Support

Resource Linkage(s) Requested (Mark All that Apply)

☐ Clothing
☐ Computer Access
☐ DMV ID Waiver
☐ Public Transportation
☐ Hygiene Kit
☐ Voter Registration
☐ Non Perishable Food
☐ Other: _____

Please provide details of needs and service(s) requested

Client Name (Print) Client Signature Date

Referring Provider/ Organization Referring Person (Print) Email Phone Number