

INSTRUCTIONS:

Email this completed form to NYCHJN@health.nyc.gov to refer yourself or a participant to the New York City Health Justice Network (NYC HJN). A NYC HJN staff member will reach out to you within four business days.

If you have any questions about NYC HJN, please email NYCHJN@health.nyc.gov or call **347-396-4663**.

SECTION 1: Participant Contact Information

Name:		Pronouns: <i>(he/him, she/her, they/their, etc.)</i>		Preferred name:	
Email:				Aliases <i>(if any)</i> :	
Phone:			Secondary Phone:		
Primary Address:			or	If no primary address:	
Apt #:				In what borough do you / does the participant reside?	
City:		ZIP:		☐ The Bronx ☐ Manhattan ☐ Brooklyn ☐ Queens ☐ Staten Island	
If we are unable to make contact, can we reach out to a secondary contact? ☐ Yes ☐ No		If yes, Secondary Contact Name:			
		Relation to participant:		Phone:	
Best way to reach you / the participant: ☐ Phone call ☐ Text ☐ Email ☐ Secondary contact ☐ In person (specify) _____ ☐ Other _____					

SECTION 2: Eligibility

Is the participant / Are you 18 years or older?	☐ Yes ☐ No
Is the participant / Are you a resident of NYC?	☐ Yes ☐ No
Was the participant / Were you released from jail, prison or youth detention/placement in the last 3 years?	☐ Yes ☐ No
Does the participant/Do you have an active open court case?	☐ Yes ☐ No

SECTION 3: How can we help? What type of services would be of interest? Choose all that apply.

☐ Healthcare Services ☐ Mental Health Services ☐ Substance Use Services	☐ Employment ☐ Housing Resources ☐ Education	☐ Benefits ☐ Legal Services ☐ Vital Documents (e.g. birth certificate, social security card) ☐ Other: _____
Is the participant / are you in crisis and in need of immediate contact? ☐ Yes ☐ No		
Anything else the participant / you would like to share with us?		

SECTION 4: Referral Information

Are you filling out this form on behalf of yourself or someone else? ☐ Self ☐ Someone else <i>(If for someone else, please continue form on other side)</i>
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NYC Health Justice Network Contact Form

If for someone else, who is making the referral:

- ☐ Community-Based Organization
 ☐ Health Center (FQHC)
- ☐ Court
 ☐ District Attorney
 ☐ Defense Attorney
- ☐ CHW Peer Navigator
 ☐ Other: _____

If CBO, which organization:

- ☐ Bronx Community Solutions
 ☐ Brooklyn Justice Initiatives
 ☐ Harlem Community Justice Center
- ☐ Manhattan Justice Opportunities
 ☐ Queens Justice Center
 ☐ Osborne Association
- ☐ Other: _____

If FQHC, which organization:

- ☐ Community Healthcare Network
 ☐ Institute for Family Health
- ☐ Other: _____

**Referring Staff
Information:**

Name:

Title:

Phone:

Email:

Click to reset form:

