

# LEGAL SERVICES REFERRAL FORM

Cravath, Swaine & Moore LLP is conducting a program to provide free legal services and advocacy to families of children receiving medical care at Morgan Stanley Children's Hospital and at the Ambulatory Care Network of New York-Presbyterian. The purpose of the project is to identify legal issues that can impact a child's medical treatment and overall health.

Date:\_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Child's Name(s):** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ Zip code: \_\_\_\_\_

**Day Time Phone Number:**\_\_\_\_\_ **Evening Phone Number:**\_\_\_\_\_

**Best time to contact client:**\_\_\_\_\_

**Person to contact if we can't reach client:**\_\_\_\_\_ **Phone:**\_\_\_\_\_

**Social worker:**\_\_\_\_\_ **Department:**\_\_\_\_\_ **Phone:**\_\_\_\_\_

**Area of legal need:** (Please check all that apply)

Housing	<input type="checkbox"/>	Public Benefits	<input type="checkbox"/>	Medicaid	<input type="checkbox"/>
Food Stamps	<input type="checkbox"/>	Employment/Child Care	<input type="checkbox"/>	Education/Special Education	<input type="checkbox"/>
Immigration	<input type="checkbox"/>	Public Assistance	<input type="checkbox"/>	Other (please specify below)	<input type="checkbox"/>

**Note:** The law firm will not be able to represent or advise patients/families in divorce, custody, child abuse, most immigration matters or criminal charges or in connection with any claims or litigation against Morgan Stanley Children's Hospital of New York-Presbyterian or any of its employees.

**Brief description of legal need, including child's medical condition: (include attachment sheets if necessary)**

Please specify if the need for legal services is an emergency and if the client has previously sought legal assistance for the problem.

[illegible]

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**Language** (If client or parent(s) has/have need for interpreter)\_\_\_\_\_

**Number of Children in Household:**\_\_\_\_\_ **Ages:**\_\_\_\_\_

**Client referred by:**\_\_\_\_\_ **Title:**\_\_\_\_\_ **Phone:**\_\_\_\_\_

I consent and authorize Morgan Stanley Children's Hospital of New York-Presbyterian and its staff to the release of the information contained on this form to Cravath, Swaine & Moore LLP so that they may review it and decide whether or not to represent my child in the above-referenced matter. I agree to complete and sign Morgan Stanley Children's Hospital of New York-Presbyterian's "Authorization to Disclose Protected Health Information/Medical Records" form.

\_\_\_\_\_  
Parent/Guardian Signature Print Name

*Please make a copy of this form and fax or email a copy and any relevant documentation to both: Felicia Stevens, Program Director (Fax 212-474-3700; Email: [fstevens@cravath.com](mailto:fstevens@cravath.com); Phone 212-474-3715), AND Lou Diozzini, Program Coordinator (Fax 212-474-3700; Email: [ldiozzini@cravath.com](mailto:ldiozzini@cravath.com); Phone 212-474-4238).*

**Please keep original and send via fax or email to Martha Bolivar (Fax: 212-305-8819; Email: [mb1451@columbia.edu](mailto:mb1451@columbia.edu))**