

ATTACHMENT A-2

**Deaf and Hard of Hearing Services (DHHS)
Resource Specialist Services
Advocacy Referral Form**

Section Required	
Requestor Contact Name:	Date:
Requestor Business:	
Requestor Address:	
Requestor Email:	Requestor Phone Number:
Complete this section for referrals	
Include a copy of the email sent to the DHHS Resource Specialist for the file.	
Client Name:	
Client Email:	Client Phone Number:
Complete this section for clients not willing to release contact information	
Include a copy of the email sent to the client providing the DHHS Resource Specialist contact information	
Reason client not willing to release contact information:	
