CENTER FOR FAMILY SERVICES INC.

Parent Resource Center – Gloucester County

Referral Form

PLEASE MAIL, FAX, or EMAIL
REFERRAL FORM and SPECIAL APPROVAL REQUEST TO:
Sara Gallagher or Richard Lange
601 S. Black Horse Pike
Williamstown, NJ 08094
PHONE: 856-728-0404 EXT. 4622 or 4614 Fax: 856-728-1407
Email: parentresourcecenter@centerffs.org

REFERRAL PROCESS

1.) **Please fill out attached referral form in its entirety.**

2.) **Fax or email referral, and Special Approval Request to Sara Gallagher or Richard Lange at Center for Family Services Inc. to the above mentioned number or email address.**

3.) **Upon receiving the referral and S.A.R., a response will be sent to the DCPP worker regarding the status of the referral, i.e. assigned an intake date, case conference with DCPP worker needed, or placed on waiting list, etc.**

4.) **Parent resource center will schedule an intake session with the parent to initiate parenting group services. During the intake visit the service objectives of parenting skills education and group assignment will be established, agreed upon and signed by all parties involved.**

If you have any questions please feel free to call Sara Gallagher at 856-728-0404 EXT. 4622, Richard Lange at 856-728-0404 EXT. 4614, or Wendy Alexander at 856-964-1990 EXT. 194

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I. REFERRAL SOURCE

DATE OF REFERRAL_____ LOCAL OFFICE: _____

REFERRING WORKER:_____TELEPHONE_____

STATE ISSUED EMAIL ADDRESS: _____

STATE ISSUED CELL NUMBER: _____

REFERRING WORKER'S SUPERVISOR_____TELEPHONE_____

II. FAMILY INFORMATION

PARENT'S NAME: _____N.J. Spirit #:_____

ADDRESS: _____

CITY: _____ZIP CODE: _____

TELEPHONE: _____PARENT'S DATE OF BIRTH_____

RACE:_____INCOME:_____

CHILDREN	SEX	AGE	BIRTHDAY

Brief Description of Family Situation: _____

_____

_____

Other Services Currently Involved with Family:

SERVICE	AGENCY	CONTACT PERSON	PHONE

List two parenting areas in which parent needs support and/or skill development:

1.) _____

_____

2.) _____

_____

III. PARENTING EDUCATION SERVICES REQUESTED

Please check (X) the following for services needed:

1. Infant/Toddler Parenting Group (0 – 4 years): _____

2. School-Age Parenting Group (5 – 12 years): _____

3. Parenting Teens/Adolescents Parenting Group (13- 17 years): _____

IV. PAYMENT SOURCE

☐ **SPECIAL APPROVAL REQUEST (must be signed and faxed with referral)**

CFS Tax ID # 22/3669704

Psycho-Social Assessment/Intake Rate: $57.80/hour (request 5 hours)

Group Parenting Classes Rate: $58.25 per session (1 ½ hours) (request 8 sessions)

Referring Worker's Signature: _____Date_____

DCPP Supervisor's Signature: _____Date _____

Client Signature: _____Date_____

For office use only: Date referral received_____

DCPP Local Office: _____

Assigned Counselor/Group: _____Date: _____