CENTER FOR FAMILY SERVICES INC.

Parent Resource Center

Referral Form

PLEASE MAIL, FAX, or EMAIL REFERRAL FORM TO:
Wendy Alexander A.V.P. or Noemi Mercado
584 Benson St.
Camden, NJ 08103
PHONE: 856-964-1990 ext. 144 or 194, Fax: 856-964-1993
Email: parentresourcecenter@centerffs.org

REFERRAL PROCESS

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

2.) Fax or email referral to Noemi Mercado or Wendy Alexander at Center for Family Services Inc. to the above mentioned number or email address.

3.) Upon receiving the referral, 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 visit with the parent to initiate services 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 Noemi at 856-964-1990 ext.144 or Wendy at 856-964-1990 ext. 194.

Parent Resource Center

Referral Form

PLEASE MAIL, FAX, or EMAIL REFERRAL FORM TO:
Wendy Alexander, Program Supervisor or Noemi Mercado
584 Benson St.
Camden, NJ 08103
PHONE: 856-964-1990 ext. 194 Fax: 856-964-1993
Email: parentresourcecenter@centerffs.org

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): _____**

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: _____Date: _____