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|  | PEACEFUL TOMORROWS Agency Referral Form |

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

# Referral Guidelines

1. Children ages 3-18 who have been exposed to domestic violence.
2. The parent survivor who is the custodial parent or guardian is usually included in the counseling.
3. Cannot be living in the same household as the person who caused the abuse.
4. Family must reside in Cumberland or Gloucester County
5. Attach a signed Release of Information (Non Center For Family Services Referrals Only)
6. Email to: [PeacefulTomorrowsCC@CenterFFS.org](mailto:mailtopeacefulTomorrowsCC@CenterFFS.org) (Cumberland) or [PeacefulTomorrowsGC@centerFFS.ORG](mailto:PeacefulTomorrowsGC@CENTERFFS.ORG) (Gloucester). Questions please call: 1.866.295.7378

(NOTE THIS IS A FILLABLE WORD DOC FORM

# Referring Agency Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Agency Name: | |  | Agency Address: |  |
| Referring Worker: | |  | Email: |  |
| Phone: | |  | Fax: |  |
| Supervisor: |  | | Email: |  |
| Phone: |  | | Fax: |  |

# Referral Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Parent/Guardian: | |  | Gender: |  |
| Language First: | | Second: |  |  |
| Street Address: | |  | City & Zip Code: |  |
| DOB: |  | | Phone Number: |  |
| Child Name & Age |  | | Child Name & Age |  |
| Child Name & Age |  | | Child Name & Age |  |
| Parent Signature: |  | | Date: |  |

# CENTER FOR FAMILY SERVICES OFFICE USE ONLY:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Time | Worker | Activity | Notes |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

11.8.23