# CENTER FOR FAMILY SERVICES INC.

## *ACTIVE PARENTING*

## *IN- HOME*

## *Parent Education Referral Form*

**PLEASE MAIL, FAX, or EMAIL REFERRAL FORM TO:**
**Wendy Alexander**
**Director of Prevention Services**
**584 Benson St.**
**Camden, NJ 08103**
**PHONE: 856-964-1990 ext. 194 Fax: 856-964-1993**
**Email: activeparenting@centerffs.org**

## *REFERRAL PROCESS*

1.) **Please fill out attached referral form in its entirety. Due to limited openings, designated allocations for each Local Office have been established for the Active Parenting program. All referrals MUST be approved and signed by each Local Office RDS before submission. No Exceptions.**

**2.) Fax or email referral to 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 DYFS worker regarding the status of the referral, i.e. assigned to parent educator, case conference with DYFS worker needed, or placed on waiting list, etc.**

**4.) DYFS will schedule an initial visit with the family to open the case with the Active Parenting program. This visit will consist of the Family, DYFS, and the Parent Educator. During the initial visit the goals / objectives of the intervention will be established, agreed upon and signed by all parties involved.**

**5.) Active Parenting in-home parent education program will hold mid-term and completion conferences with DYFS and families to discuss overall progress towards goals.**

**If you have any questions please feel free to call Wendy at 856-964-1990 ext.194 or Noemi at 856-964-1990 ext. 144.**

**Please fax/forward the following information with the referral:**

**-MOST RECENT CASE PLAN**
**-PSYCHOLOGICAL OR PSYCHIATRIC HISTORY**
**-ANY COURT INVOLVEMENT**

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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 Instruction (0 – 4 years): _☐_**
2. **School-Age Parenting Instruction (5 – 12 years): _☐_**
3. **Parenting Teens/Adolescents Parenting Instruction (13- 17 years): _☐_**

**Referring Worker's Signature: _____Date_____**

**DYFS Supervisor's Signature: _____Date _____**

**RDS Approval Signature: _____Date_____**

**Client Signature: _____Date_____**

**For office use only:** **Date referral received** 7/6/2010

**DYFS Local Office: _____**

**Assigned counselor: _____Date: _____**