CENTER FOR FAMILY SERVICES INC.

ACTIVE PARENTING

IN-HOME

Parent Education Referral Form

PLEASE MAIL, FAX, or EMAIL REFERRAL FORM TO:
Jamie O’Brien, Program Supervisor, Wendy Alexander A.V.P.
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 Jamie O’Brien 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 to parent educator, case conference with DCPP worker needed, or placed on waiting list, etc.

4.) DCPP will schedule an initial visit with the family to open the case with the Active Parenting program. This visit will consist of the Family, DCPP, 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 DCPP and families to discuss overall progress towards goals.

If you have any questions please feel free to call Jamie at 856-964-1990 ext.141 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:_________________________

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Brief Description of Family Situation: _______________________________________

________________________________________________________________________

________________________________________________________________________
Other Services Currently Involved with Family:

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<th>SERVICE</th>
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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 ______________
DCPP Supervisor’s Signature: ____________________________ Date ______________
RDS Approval Signature: ________________________________ Date ______________
Client Signature: _____________________________________ Date ______________

For office use only: Date referral received ________________
DCPP Local Office: ____________________________
Assigned counselor: ____________________________ Date: ______________