

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: _____

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** _____

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:** _____