CENTER FOR FAMILY SERVICES

Parent Resource Center – Camden County

Referral Form

PLEASE EMAIL REFERRAL FORM:
Lisa.Tyson@centerffs.org

<table>
<thead>
<tr>
<th>MAIN CONTACT</th>
<th>ALTERNATE CONTACT</th>
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<tbody>
<tr>
<td>Program Director: Lisa Tyson</td>
<td>Administrative Assistant: Blanca Rodriguez</td>
</tr>
<tr>
<td>Cell Phone: 609-230-9995</td>
<td>Cell Phone: 609-471-9251</td>
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<tr>
<td>Email: <a href="mailto:Lisa.Tyson@centerffs.org">Lisa.Tyson@centerffs.org</a></td>
<td>Email: <a href="mailto:Blanca.Rodriguez@centerffs.org">Blanca.Rodriguez@centerffs.org</a></td>
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REFERRAL PROCESS

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

2.) Please email the referral to Lisa Tyson at Lisa.Tyson@centerffs.org

3.) Upon receiving the referral, a response will be sent to the DCPP worker regarding the status of the referral.

4.) Parent Resource Center will schedule an intake session with the parent to initiate 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. The intake will be completed via telehealth with video conference.

5.) The parenting groups will be conducted via telehealth with video group conference. The groups will be Tuesday, Wednesday or Thursday 11:00 AM-12:30 PM.
Parent Resource Center- Camden County

Referral Form

PLEASE EMAIL REFERRAL FORM TO:

Program Director: Lisa Tyson
Email: Lisa.Tyson@centerffs.org Cell Phone: 609-230-9995

I. REFERRAL SOURCE

DATE OF REFERRAL_______________ LOCAL OFFICE: _________________________

REFERRING WORKER:___________________________ CELL NUMBER: ______________

EMAIL ADDRESS:___________________________ DCP&P Supervisor: ______________

CELL NUMBER:___________________________ EMAIL ADDRESS: ______________

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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<th>CHILDREN</th>
<th>SEX</th>
<th>AGE</th>
<th>BIRTHDAY</th>
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Brief Description of Family Situation: ________________________________________________
________________________________________________________________________________
________________________________________________________________________________


Other Services Currently Involved with Family:

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<th>SERVICE</th>
<th>AGENCY</th>
<th>CONTACT PERSON</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 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 ______________