CENTER FOR FAMILY SERVICES INC.

Parent Resource Center – Gloucester County

Referral Form

PLEASE MAIL, FAX, or EMAIL
REFERRAL FORM and SPECIAL APPROVAL REQUEST TO:
Sara Gallagher or Richard Lange
601 S. Black Horse Pike
Williamstown, NJ 08094

PHONE: 856-728-0404 EXT. 4622 or 4614  Fax: 856-728-1407
Email: parentresourcecenter@centerffs.org

REFERRAL PROCESS

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

2.) Fax or email referral, and Special Approval Request to Sara Gallagher or Richard Lange at Center for Family Services Inc. to the above mentioned number or email address.

3.) Upon receiving the referral and S.A.R., a response will be sent to the DCPP worker regarding the status of the referral, i.e. assigned an intake date, case conference with DCPP worker needed, or placed on waiting list, etc.

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.

If you have any questions please feel free to call Sara Gallagher at 856-728-0404 EXT. 4622, Richard Lange at 856-728-0404 EXT. 4614, or Wendy Alexander at 856-964-1990 EXT. 194
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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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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): __________

IV. PAYMENT SOURCE

☐ SPECIAL APPROVAL REQUEST (must be signed and faxed with referral)

CFS Tax ID # 22/3669704
Psycho-Social Assessment/Intake Rate: $57.80/hour (request 5 hours)
Group Parenting Classes Rate: $58.25 per session (1 ½ hours) (request 8 sessions)

Referring Worker’s Signature: ____________________________ Date ________________
DCPP Supervisor’s Signature: ____________________________ Date ________________
Client Signature: ______________________________________ Date ________________

For office use only: Date referral received ______________________
DCPP Local Office: ________________________________
Assigned Counselor/Group: ____________________________ Date: ________________