CENTER FOR FAMILY SERVICES INC.

Parent Resource Center

Referral Form

PLEASE MAIL, FAX, or EMAIL REFERRAL FORM TO:
Wendy Alexander A.V.P. or Noemi Mercado
584 Benson St.
Camden, NJ 08103
PHONE: 856-964-1990 ext. 144 or 194, Fax: 856-964-1993
Email: parentresourcecenter@centerffs.org

REFERRAL PROCESS

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

2.) **Fax or email referral to Noemi Mercado 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 an intake date, case conference with DCPP worker needed, or placed on waiting list, etc.**

4.) **Parent resource center will schedule an intake visit with the parent to initiate services 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 Noemi at 856-964-1990 ext.144 or Wendy at 856-964-1990 ext. 194.

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PLEASE MAIL, FAX, or EMAIL REFERRAL FORM TO:

Wendy Alexander, Program Supervisor or Noemi Mercado
584 Benson St.
Camden, NJ 08103
PHONE: 856-964-1990 ext. 194 Fax: 856-964-1993
Email: parentresourcecenter@centerffs.org

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 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** ______________

RDS Approval Signature: ______________________________**Date**______________

Client Signature: ______________________________________**Date**______________

For office use only: **Date referral received**____________________

DCPP Local Office: ______________________

Assigned counselor: ___________________________**Date:** __________________