CENTER FOR FAMILY SERVICES

TAFCAR (Treatment Alternatives for Children at Risk) – Gloucester County

PLEASE FAX or EMAIL

REFERRAL FORM and SPECIAL APPROVAL REQUEST TO:

Program Supervisor: Alyssa Shilinsky
PHONE: 856-728-0404 EXT. 4622      Fax: 856-728-1407
Email: alyssa.shilinsky@centerffs.org

Alternate Contact- Program Director: Sara Gallagher
Phone: 856-964-1990 EXT. 108      Email: sgallagher@centerffs.org

REFERRAL PROCESS

1.) Please fill out attached referral form to its entirety. Please send supporting documents; i.e. case plan, court orders, and any evaluations for the children and/or parents.

2.) Fax the referral to Alyssa Shilinsky at the TAFCAR program at 856-728-1407. Upon receiving the referral, an email will be sent to the DCP&P referring worker in reference to the status of the referral, and the assigned TAFCAR worker.

3.) The DCP&P case worker, family, and TAFCAR worker must all be present at the intake.

4.) During the initial visit, the family’s goals and objectives of the intervention will be established, agreed upon, and signed by all parties involved.

5.) There should be ongoing contact between all parties regarding the status of the intervention. TAFCAR will send monthly updates to DCP&P regarding the family’s progress.

6.) TAFCAR Gloucester County will provide services for 12 weeks. When the 12 weeks are coming to a close, all parties will explore the need for case closure or the need to extend services.
CENTER FOR FAMILY SERVICES

TAFCAR REFERRAL FORM

Phone: 856-728-0404 EXT. 4622
Fax: 856-728-1407

Instructions: Please fill out all sections of the referral. When faxing the referral, please include DCP&P case plan, court order, any evaluations for the child(ren) and parents, and any other documents that you feel may be helpful to TAFCAR. Also, be sure to attach the SAR. SAR instructions will be outlined below.

Date of Referral: ____________________ DCP&P Local Office: ____________________

DCP&P Referring Worker: ____________________ Office #: ____________________

State Issued Cell Phone: _______________ Email Address: ____________________

DCP&P Supervisor: ____________________ Office #: ____________________

DCP&P Supervisor Email Address: ____________________

FAMILY INFORMATION

Family/Case Name: ____________________ NJ Spirit Number: ____________________

Address: ____________________ City: ____________________ Zip Code: ____________________

Home Telephone: ____________________ Cell Telephone: ____________________

PLEASE LIST OFF ALL HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>First &amp; Last Name</th>
<th>Sex</th>
<th>Age</th>
<th>Date of Birth</th>
<th>Race</th>
<th>Relationship</th>
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Has this family been informed about TAFCAR services? Yes _____ No _____
Date of last home visit by DCP&P: ____________

*If yes, is the family available for services between the hours of 9am to 6pm? Yes ___ No ____ If the family isn’t available during these hours, this case may not be appropriate for TAFCAR. TAFCAR Supervisor will conference this case with DCP&P staff.*

Brief Family History: ____________________________________________

_________________________________________________________________

Goals of TAFCAR services for the family?

1. ___________________________________________________________________

2. ___________________________________________________________________

3. ___________________________________________________________________

Please fill out in regards to the current services the family is involved in.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Type of Service</th>
<th>Provider Name</th>
<th>In-home or out of home service?</th>
<th>Frequency of Service</th>
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PAYMENT SOURCE

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

CFS Tax ID # 22/3669704

TAFCAR RATE: $203.00 per week x 12 (weeks) = $2436.00

**Please put the service start date for when you and the family will be available for the intake**

DCP&P Referring Worker’s Signature: ___________________________ Date: ____________

DCPP Supervisor’s Signature: ___________________________ Date: ____________

Resource Development Specialist Signature: ___________________________ Date: ____________