CENTER FOR FAMILY SERVICES

Parent Resource Center – Gloucester County

Referral Form

PLEASE EMAIL REFERRAL FORM and SPECIAL APPROVAL REQUEST TO:

Lisa.Tyson@centerffs.org

MAIN CONTACT	ALTERNATE CONTACT
Program Director: Lisa Tyson	Group Facilitator: Julia Mullin
Cell Phone: 609-230-9995	Cell Phone: 856-701-3814
Email: Lisa.Tyson@centerffs.org	Email: Julia.Mullin@centerffs.org

REFERRAL PROCESS

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

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

3.) Upon receiving the referral and SAR, 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 Wednesdays 12:30-2:00 PM.

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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:_____

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): _____**

IV. PAYMENT SOURCE

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

****Please allow 6 months for the expiration date****

Intake SAR	
CFS TAX ID or FED ID #:	223669704
Resource #:	10000065
Service Name:	D03p_Individual Counseling/Therapy
Current Base Rate:	$57.80
Estimated Units Per Month:	5

Group SAR	
CFS TAX ID or FED ID #:	223669704
Resource #:	10000065
Service Name:	D03q_Grp Counseling/Therapy - Physician
Current Base Rate:	$58.25
Estimated Units Per Month:	8

Referring Worker's Signature: _____Date_____

DCPP Supervisor's Signature: _____Date _____