Multi-Therapy Services, Inc.
THE LEADING AGENCY IN THE HEALTH & HUMAN SERVICES FIELD

DCP&P Visitation Services Referral Form

Multi-Therapy Services, Inc.
900 Haddon Avenue Suite 233
Collingswood, New Jersey 08108

Phone 856-240-7070 Fax 609-482-8850 On-Call Cell Phone 609-381-4068
Fed ID # 51-0390702

DCPP Office: ___________________**Date Referral was completed:** ______________

Services Requested: ___ **Creative Visitation-$92** ___**Therapeutic Visitation- $125**

Case Manager: ____________________**Office # and Ext.**______________________

DCPP Cell #_______________________ **CM Email:** __________________________

Case Manager Signature ___________________________**Date** ________________

Supervisor Signature (required):____________________ **Date** ________________

Supervisor's Phone # ___________________________ **Supervisor Email:**_____________________

RDS signature (required) _________________________ **Date** ________________

RDS Email: _____________________________

NJ Spirit #_______________________________________

MUST BE COMPLETED

# of Hours requested for Week___________ **Time of Face-to-face**_________

Length of face to face visit (hours) ____________________

Day(s) Requested ___________________________________

- **One Time Visit or Continuous Visits**

- **Court Ordered Services Yes or No**

Person who is visiting with the children:
Non-Custodial Parent/Guardian
Information____ Date of Birth:
____

Case Number# ____________________________

Race: ____________________ Gender__________________________

Address: ____

Home Phone # _______________________ **Cell Phone #** ______________________

Location of the visit: DCP&P Office Location ___________**MTS Office** __________

Home: ____
Community: ________ **What are the approved/appropriate community locations:**
____
____
____

Did you discuss this service with the consumer/client? ______________
(if no, please discuss this service with the consumer/client before making this referral)

Reason for Referral/Presenting Problem or Conditions/History of Violence if Relevant
(Please Be Specific) ____
____

Anticipated outcome that the case manager wants for the consumer/client and or Family:
____
____
____

Special request or Other Pertinent Information: _________________________________
____
____

Please check the areas you would like MTS to assist:
__ Advocacy Skills
__ Budgeting
__ Communication Skills
__ Coping Skills/ Stress Management
__ Discipline
__ Employment
____ Home Management
____ Housing
____ Community Resources
____ Nutrition
____ Parenting
____ Other (please Specify)

Is the client receiving any other services? __________ If yes, what type of service?____ Are they in good standing in the program? _______

What is the permanency plan for the family? Is there a secondary goal?____
____

If the plan is reunification, what is the tentative date for reunification? _____________

Children who are attending visiting services:

Child #1 Name: ________________________Date of Birth_____________Age_________

Race: __________________________ Gender______________

Current Caregiver: ________________________________

Address: ____

Home Phone #_____________________ Cell Phone # _______________________

Initial Placement Date: ________________________
# of placements________________

Date placed in current residence: ______________________

If placed with a relative, how are they related? ___________________

Who has legal custody? ___________________________

Child #2 Name: ________________________Date of Birth_____________Age_________

Race: __________________________ Gender______________

Current Caregiver: ________________________________

Address: ____

Home Phone #_____________________ Cell Phone # _______________________

Initial Placement Date: ________________________
# of placements________________

Date placed in current residence: ______________________

If placed with a relative, how are they related? ___________________

Who has legal custody? ___________________________

Child Name: ________________________Date of Birth_______________Age_______

Race: __________________________ Gender______________

Current Caregiver: ________________________________

Address: ____

Home Phone #_____________________ Cell Phone # _______________________

Initial Placement Date: ________________________

# of placements________________

Date placed in current residence: ______________________

If placed with a relative, how are they related? ___________________

Who has legal custody? ___________________________

Child #3 Name: ________________________Date of Birth____________Age__________

Race: __________________________ Gender______________

Current Caregiver: ________________________________

Address: ____

Home Phone #_____________________ Cell Phone # _______________________

Initial Placement Date: ________________________
# of placements________________

Date placed in current residence: ______________________

If placed with a relative, how are they related? ___________________

Who has legal custody? ___________________________

Transportation Needs -Please be specific and include the following:

Name and Pick Up Locations :
Include the Name of person (or facility) we are picking the client up from):
Child 1:
____
____

Child 2:
____
____

Child 3:
____
____
____

Child 4:____
____

Additional children:
____
____
____

Location of face to face visit:
____

Who is allowed to participate in the visit (approved visitors)
____
____
____

Drop off Location(s) :
Child 1:
____
____

Child 2:
____
____

Child 3:
____
____
____

Child 4:____
____

Additional children:
____
____
____

Please submit copy of Special Request (SAR) and attach a recent copy of the court order and any other collateral information that may be of importance for the services.

If this referral is not filled out in its entirety we will not be able to service this case.