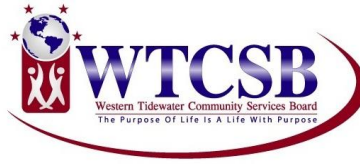


WESTERN TIDEWATER COMMUNITY SERVICES BOARD



**Strong African American Families Program**

**SECTION I: REFERRAL INFORMATION**

Date of Referral: ____/____/____	Preferred Service Location <input type="checkbox"/> Franklin <input type="checkbox"/> Southampton
<b>Referring Agency</b>  COURT <input type="checkbox"/> Franklin <input type="checkbox"/> Southampton  SCHOOLS <input type="checkbox"/> Franklin <input type="checkbox"/> Southampton  DEPT of SOCIAL SERVICES <input type="checkbox"/> Franklin <input type="checkbox"/> Southampton  <input type="checkbox"/> Other: _____ <input type="checkbox"/> Self: _____ <input type="radio"/> Court Order	Agency Representative: <hr/>

**SECTION II: FAMILY INFORMATION**

**Parent(s) Name and Address**

First Name	MI.	Last Name
Street	City/State	Zip Code

Phone number: \_\_\_\_\_

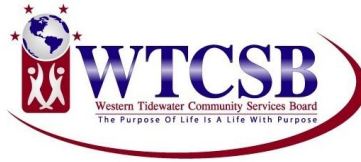
**SECTION III: REASON FOR REFERRAL**

\_\_\_\_\_

WESTERN TIDEWATER COMMUNITY SERVICES BOARD

Please return completed form to:  
Attn: Dametrice Goodwyn, Site Coordinator  
Latril Mariano, Child & Family Service Manager  
Fax: (757) 925-2221  
Dametrice (office): 942-1955  
Latril (office): 942-1963

**WESTERN TIDEWATER COMMUNITY SERVICES BOARD**

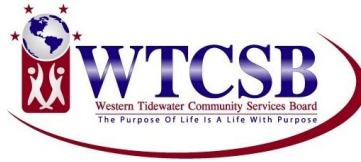


**Strong African American Families Program**

HEAD OF HOUSEHOLD:		
ADDRESS:		
PHONE NUMBER:		
NUMBER OF CHILDREN:		
NAMES/ AGES OF CHILDREN: BIRTH DATE:		

To be completed by WTCSB Site Coordinator

**WESTERN TIDEWATER COMMUNITY SERVICES BOARD**



**Strong African American Families Program**

ANY FOOD ALLERGIES? Yes:            No:	
TRANSPORTATION REQUIRED? Yes:            No:	
AVAILABLE DATES/TIMES :	SAAF Start Date:
The first session will be the pre-post test and a planned lesson from the curriculum. Food and transportation are provided (if required) on a session basis. Completion of the full 7 week program is required to participate in graduation. If by chance a class must be missed please contact the group facilitator and/or site coordinator.	Are you able to agree to these terms?  Yes:  No:
Notes:	

Date of Referral: \_\_\_\_\_

Approved: \_\_\_\_\_

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date