WESTERN TIDEWATER COMMUNITY SERVICES BOARD

Strong African American Families Program

SECTION I: REFERRAL INFORMATION	
Date of Referral: _____/_____/_____	Preferred Service Location □Franklin □Southampton
Referring Agency COURT □Franklin □Southampton SCHOOLS □Franklin □Southampton DEPT of SOCIAL SERVICES □Franklin □Southampton □Other: _____ □ Self: _____ ○ Court Order	Agency Representative: _____

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

Form Approved 11/11/14

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

Form Approved 11/11/14

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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

Form Approved 11/11/14