



Official Use ONLY

To be completed by Care Plus NJ, Inc. BCJFPP Staff
Once Referral has been accepted.

Client Name: _____

I.D. #: _____ **Date:** _____

Clinician Name & Title:

BERGEN COUNTY JUVENILE FIRE PREVENTION PROGRAM

17-07 ROMAINE STREET FAIRLAWN, NJ 07410
(201) 797-2660 EXT. 144 (OFFICE) Program Manager
(201) 797-5025 (FAX)

REFERRAL FORM

PLEASE COMPLETE FORM (PRINT OR TYPE) FOR REFERRAL TO BE PROCESSED

DATE: _____

TO: Program Manager
CPNJ-Bergen County Juvenile Fire Prevention Program

FROM: _____ REFERRAL AGENCY: _____

PHONE: _____ FAX: _____

Based on the incident which occurred _____
(description of event or refer to attached paperwork)

The following juvenile and his/her parents have been referred to the Bergen County Juvenile Fire Prevention Program (BCJFPP): _____ and his/her parents _____
(Juvenile's Name) (Parent's Name)

Please note the following information:

(Address)

(Phone Number) (DOB)

This case is scheduled for review on _____
(Date)

I/We have been advised of the referral and the services offered by the BCJFPP. I/We have been made aware that a failure to comply with the referral to BCJFPP will be reported back to the Referring Agency. I/We understand that the information supplied to BCJFPP and shared during counseling is confidential with the exception of information that causes concern for safety (i.e. – child is at-risk of seriously hurting self or someone else, report of child being hurt by others) and will not otherwise be released from BCJFPP without the written consent of the juvenile and/or his/her parent/guardian.

(Signature of parent/legal guardian) Date

(Signature of Juvenile if 14 or older) Date

Submitted on behalf of Referral Agency by: _____
(Signature)