CHILDREN'S FRIEND & FAMILY SERVICES
A DIVISION OF JRI

Referral – In-Home Therapy

Date of Referral: _____

☐ **Lynn:** p: 781.593.7676 **Please fax to: 781.595.1081** ☐ **Merrimack Valley:** p: 978.682.7289 **Please fax to: 978.686.2954**

☐ **Salem:** p: 978.744.7905 **Please fax to: 978.740.9145** ☐ **Gloucester:** p: 978.283.7198 **Please fax to: 978.281.7793**

Eligibility Criteria: (Please Check all that Apply)

☐ The child/youth is under 21 and has Mass Health; MBHP, Network Health, Neighborhood Health Plan, BMC HealthNet, or Fallon.
☐ Youth has a parent/guardian/caregiver who voluntarily agrees to participate in this service and agrees to provide consent.
☐ Outpatient services alone are not sufficient to meet the youth's needs for coaching, support, and education.
☐ If a Comprehensive Assessment and CANS have been completed, please forward with this referral.

Child/Youth Information:

Preferred Language: ☐**English** ☐**Spanish** ☐**Other:** _____

Name: _____ **D.O.B:** _____

School: _____ **Grade:** _____ **IEP?** ☐Yes ☐No

Primary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** _____

Secondary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic, Latino, or Spanish Origin ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Declined to Specify ☐ Other Race:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify **SS#:** _____

Gender: ☐Declined to Specify ☐Female ☐Gender Fluid ☐Gender Queer ☐ Male ☐Non-Binary ☐Other/Non-conforming ☐Trangender Man ☐Transgender Woman

Psychiatric Diagnosis*: **DSM Code:** _____ **Narrative:** _____

DSM Code: _____ **Narrative:** _____

***Who generated dx and when?** _____ _____

****Including this information significantly assists in ability to gain authorization for service. Please include when at all possible.***

PCP: _____

Allergies/Medical Conditions/Medications:

Parent/Guardian Information:

Preferred Language: ☐**English** ☐**Spanish** ☐**Other:** _____

Name: _____ **Relationship to Child:** _____

Address: _____ **Home Telephone:** _____

Cell Phone: _____ **Other Telephone:** _____

Best Times to Call/Scheduling Needs: _____

Legal Guardian (☐same as above): _____

Physical Custody: (☐same as above): _____

Where does child currently live? ☐With Parent(s)/Guardian(s) ☐Foster Home ☐Group Home ☐Other:

If not with parent(s)/guardian(s) listed above, please give name, address, and telephone number of current residence:

Emergency Contact Information (please identify a secondary person to contact if parent/guardian is not able to be reached):

Preferred Language: ☐**English** ☐**Spanish** ☐**Other:** _____

Name: **Relationship to Child:**

Cell Phone: **Home Telephone:**

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Person Making Referral:			
Name and Role:			
Fax:		**Organization:**	
Address:		**Work Phone:**	
E-mail:		**Cell Phone:**	

Referral Source Type: ☐ CBAT/TCU ☐ CSA ☐ DCF ☐ DYS ☐ Family/Youth ☐ Hospital ☐ In-Home Services ☐ MCI ☐ Outpatient ☐ PCP ☐ School ☐ Other:

Known Services/Agency Involvement:

	Past	Current	Unknown	Contact Person and Telephone and/or e-mail
☐ Department of Children and Families (DCF)	☐	☐	☐	
☐ Department of Mental Health (DMH)	☐	☐	☐	
☐ Department of Youth Services (DYS)	☐	☐	☐	
☐ Child Requiring Assistance (CRA)/Court	☐	☐	☐	
☐ In Home Therapy/FST	☐	☐	☐	
☐ Therapeutic Mentoring/Other Mentoring	☐	☐	☐	
☐ In-Home Behavioral Services	☐	☐	☐	
☐ Therapy/Counseling/Outpatient Services	☐	☐	☐	
☐ Psychopharmacology/Psychiatry Services	☐	☐	☐	
☐ Hospitalized	☐	☐	☐	
☐ ER visit or screened in last 6 months	☐	☐	☐	
☐ Other:	☐	☐	☐	

Brief description of your concerns and goals in referring child (please include any current safety concerns):

Risk Factors: ☐DV ☐Mental Illness ☐Substance Use ☐Abuse ☐Neglect ☐Medical Issues ☐Cultural Factors ☐Suicidal/Homicidal Ideation ☐ Other: