Justice Resource Institute, Inc.
GRIP Community Based Services

476 Appleton Street #5 Holyoke, MA 01040
Phone (978) 799-7397 Fax (413) 322-0496

INSTRUCTIONS: Please fill out this referral form as completely as possible.

For **In-Home Therapy or Therapeutic Mentoring** services we accept Massachusetts Behavioral Health Partnership, HNE Be Healthy, Beacon and Tufts Health Together MassHealth insurance plans as well as select Blue Cross Blue Shield plans.

Please note: Therapeutic Mentoring referrals are only accepted from the child's Outpatient Therapist, In Home Therapist or Intensive Care Coordinator, and must include a copy of the most recent CANS, Comprehensive Assessment, the child's safety plan and current Treatment Plan/Care Plan including TM treatment objectives.

Once completed, please FAX or EMAIL referral form to:
Morganne Crouser at 413-322-0496 or mcrouser@jri.org.

Child's Name: ___________________________ Date of Birth: __________

Identified Gender: ________________ Race: ______________ Age: __________

Address: ___________________________________ Zip: ______________

Does the child speak English? ☐ yes ☐ no Preferred Language: ________________

Accommodations Required: ______________________________ ☐ Not Applicable

Insurance Plan: __________________________ SSN: ____________________

Policy Number (MMIS):______________________ MCO: ☐ Tufts Health Together ☐MBHP ☐HNE Be Healthy Beacon BCBS

Referral for: ☐ In Home Therapy ☐ Therapeutic Mentoring TM referrals must include the most recent Treatment/Care Plan, CANS, Comprehensive Assessment, and Safety Plan.

Guardian's Name(s): ______________________ Relationship to Person: ____________

Preferred Method of Contact: ☐ phone ☐ email ☐ text Phone: ____________________

Best time for Contact: ☐ morning ☐ afternoon ☐ evening Email: ____________________

Alternate Phone:______________________ Communication Needs: ________________

Does the guardian speak English? ☐ yes ☐ no Preferred Language: ________________

Is the child in DCF custody? ☐ yes ☐ no Are there any outstanding 51A's? ☐ yes ☐ no

Source of Referral: ☐ Outpatient therapist ☐ In Home Therapist ☐ Intensive Care Coordinator ☐ DCF ☐ Family/Self ☐ Other: __________________________

Name of Person making referral: _____________________________ Date: __________

Referring Agency:______________________ Phone: ____________________

Email: ___________________________ Fax: ____________________

Please include signed Release of Information with Referral if Applicable

Current Diagnosis Disorders and Conditions: (Please include DSM-5 and/or ICD-10 codes)

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Reason for Referral:

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Has the parent/guardian agreed to In Home Therapy or Therapeutic Mentoring services? ☐ yes ☐ no

Has the child agreed to In Home Therapy or Therapeutic Mentoring services? ☐ yes ☐ no

Precipitants to Referral: (Family, friends, or school stressors? Recent upsetting events? High risk factors?)

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Previous Mental Health Treatment: ☐Not Applicable

Provider:_________________________ Dates:________ ☐ Inpatient/Residential ☐ Outpatient

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Provider:_________________________ Dates:________ ☐ Inpatient/Residential ☐ Outpatient

Is the child <u>currently</u> placed in an inpatient or residential program? ☐ no ☐ yes

If yes: ☐ Inpatient Psychiatric ☐ CBAT/ICBAT ☐ TCU ☐ STARR ☐ Res. Ed./Group Home ☐ Other

Name of Program: ______________________________ Anticipated Discharge Date: ________

Short Term Treatment Recommendations for In Home Therapy or Therapeutic Mentoring:

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Medical Information:

Allergies: ______________________________ ☐No known allergies

Medication: ____________ Dose:______ Medication: ____________ Dose:______

Medication: ____________ Dose:______ Medication: ____________ Dose:______

Medication: ____________ Dose:______ Medication: ____________ Dose:______

Prescriber: ________________ Phone: ____________ ☐Not Applicable

Current Services and Support:

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Child's Emergency Contact:

Name: ________________ Phone: ________________

Address: ______________________________ Zip: ____________

School: ☐Not Applicable

Name:________________ City/Town:__________ Grade:________

Contact Name: ________________ Phone: ________________

Outpatient Therapist: ☐Not Applicable

Name: ________________ Phone: ________________

Address: ______________________________ Zip: ____________

Other Behavioral Health Provider: ☐Not Applicable

Name: ________________ Phone: ________________

Address: ______________________________ Zip: ____________

State Agency (DCF/DMH/DYS/DDS) Contact Person: ☐Not Applicable

Name:________________ Phone: ____________ Agency:_______

Address: ______________________________ Zip: ____________

Signature of Referral Source: ________________ **Referral Date**: __________