Metro Boston Community Based Services

REFERRAL FORM

Date of Referral:_____

☐ **In-Home Therapy (IHT)** ☐ **Therapeutic Mentoring (TM)**
☐ **DCF Support & Stabilization**

Juvenile Justice Involved: ☐ **Yes** **LGBTQ+:** ☐ **Yes**

Eligibility Criteria for CBHI:

- Youth is under 21and has one of the following **MassHealth Plans: MassHealth Family Assistance, Tufts Public Health Plan, HNE, Beacon BMC, Beacon Fallon, Always Health Partners My Care Family, and MBHP**.
- Youth meets medical necessity criteria.
- Youth's parent/guardian voluntarily agrees to participate in services and to provide consent.
- TM referrals are made by youth's Outpatient Therapist, IHT, or ICC. Please attach a copy of the CANS, Comprehensive Assessment, and current Individualized Action Plan.

Eligibility Criteria for Behavioral Health Services for Children and Adolescents (BHCA):

- Youth is under 19 and has one of the following **Commercial Health Plans (BCBS of MA, Beacon BMC/Fallon Commercial Plans, Beacon Fallon/Ultra Benefits/Fallon Select, Unicare GIC, Tufts Health Direct, Always Health Partners, Harvard Pilgrim, and United Healthcare).** Contact insurance company for confirmation of these benefits.
- Youth's parent/guardian voluntarily agrees to participate in services and to provide consent.
- Youth meets medical necessity criteria.

Please EMAIL Referral Form & Documents to: Alicia Straus, LICSW at astraus@jri.org or FAX at (617) 522-3059

CHILD/YOUTH INFO: Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Name: _____ DOB: _____ Identified Gender: _____

Ethnicity: _____ Race: _____ Allergies: _____

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

Current Diagnosis / ICD-10 Code (by whom & when): _____

Current Medications and Doses: _____

Name of Doctor Prescribing Medications: _____ Phone: _____

PRIMARY Insurance: _____	**SECONDARY Insurance (If applicable):** _____
Subscriber/MHIS #: _____	**Subscriber/MHIS # (If applicable):** _____

PARENT/GUARDIAN INFO: Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Name(s): _____ Relationship to Youth: _____

Address: _____

Cell/Home Phone: _____ Email: _____

Has the Family Agreed to Services? ☐ Yes ☐ No Has Youth Received Services Here Before: ☐ Yes ☐ No

EMERGENCY CONTACT (If Available):

Name(s): _____ Relationship to Youth: _____

Address: _____

Cell/Home Phone: _____ Email: _____

NAME OF PERSON MAKING REFERRAL: _____ Organization: _____

Email: _____ Phone: _____ Relationship: _____

Level of Care: ☐ ACO ☐ CBAT/TCU ☐ Court ☐ CSA ☐ DCF ☐ DMH ☐ DYS ☐ Family/Youth ☐ Hospital ☐ In-Home ☐ Mobile Crisis ☐ Outpatient ☐ PCP ☐ Probation ☐ School ☐ Other:

Reasons for Referral (please include any safety concerns): _____

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Past & Current Risk Factors: ☐ DV ☐ Substance Use ☐ Abuse ☐ Neglect ☐ Medical Issues ☐ Cultural Factors ☐ Family Conflict ☐ Suicidal/Homicidal Ideation ☐ Academic Performance/Truancy ☐ Community Violence/Gang Involvement ☐ Other _____

OTHER AGENCIES & CARE PROVIDERS:

	Current	Past	Unknown	Contact Person & Telephone/Email
☐ DCF	☐	☐	☐	_____
☐ DMH	☐	☐	☐	_____
☐ DYS	☐	☐	☐	_____
☐ Court/CRA	☐	☐	☐	_____
☐ Probation	☐	☐	☐	_____
☐ PCP	☐	☐	☐	_____
☐ Dentist	☐	☐	☐	_____
☐ Psychiatrist	☐	☐	☐	_____
☐ Outpatient	☐	☐	☐	_____
☐ ICC/FP	☐	☐	☐	_____
☐ IHT/TM	☐	☐	☐	_____
☐ IHBS	☐	☐	☐	_____
☐ ER Visit Last 6 Month	☐	☐	☐	_____
☐ Hospitalized	☐	☐	☐	_____
☐ Other	☐	☐	☐	_____

INTERNAL USE:

Date of Referral	_____
Date of Documents Received from Hub	_____
Date Assigned & to Whom	_____
Dates Outreach Attempts to Caregiver	**Outcomes**
_____	_____
	_____
Date Appointment Offered	_____
Date of Caregiver/Gardian Consent	_____
Date Services Started	_____

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