In-Home Behavioral Services Referral Date of Referral: _______________

☐ **Merrimack Valley:** p: 978.682.7289 **Please fax to: 978.686.2954 or email to** kengel@jri.org

***Please send supporting documentation with referral such as Care Plan, CANS, Comprehensive Assessment and treatment**

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.

☐ Less intensive behavioral interventions have not been successful in reducing or eliminating the problem behavior(s) or increasing or maintaining desirable behavior(s).

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 ☐Transgender 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:**

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	Currentt	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:	☐	☐	☐	

CHILDREN'S FRIEND & FAMILY SERVICES
A DIVISION OF JRI

Briefly state reason for referral and describe the specific behaviors which prompted the referral:

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