JRI_logo_screen

Boston GLASS Community-Based Services

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| Administrative Office  3313 Washington Street, Second Floor  Jamaica Plain, MA 02130  Phone (781) 854-8564 / Fax (617) 522-3059 | Boston GLASS (GLBTQ Adolescent Social Services)  555Amory Street, Suite 3  Boston, MA 02130  Phone (857) 399-1920 |

**INSTRUCTIONS:**

**Please fill out this referral form as completely as possible.**

For **In-Home Therapy (IHT) or Therapeutic Mentoring (TM)** we accept MassHealth covered under:

Massachusetts Behavioral Health Partnership, Boston Medical Center HealthNet Plan, Tufts Health Plan,

Neighborhood Health Plan, & Fallon Community Health Plan; and some Beacon and Blue Cross Blue Shield

plans. We also accept Behavioral Health for Children and Adolescents (BHCA)

**TM referrals** are made by a person’s Outpatient Therapist, IHT or ICC.

Please attach copies of the CANS, Comprehensive Assessment, and the person’s current Treatment Plan

with goals of TM services identified. Services cannot start until all paperwork is received.

**EMAIL referral packet to Alicia Straus, LICSW at astraus@jri.org.**

Do the youth and family desire specialized care for LGBTQ+ members? \_\_\_\_ Y \_\_\_\_ N

Youth’s (Chosen) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_

Gender Identity (how the youth identifies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Racial Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Youth’s Name on Health Insurance (if different)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Caregiver Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver’s Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Youth: \_\_\_\_\_\_\_\_\_\_\_\_

Does the caregiver speak English? \_\_\_\_Y \_\_\_\_N Preferred Language(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Source of Referral: (Please circle or underline) OPT IHT ICC Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person making referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the family agreed to services? \_\_\_\_ Y \_\_\_\_ N

Has client received services at Boston GLASS or JRI before? \_\_\_\_Y\_\_\_\_N

Service Desired: (Please circle or underline): Therapeutic Mentoring In-Home Therapy

\*If you are referring for TM, who is the clinical hub? (A clinical hub can be a therapist completing the CANS Assessment, or an ICC)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Insurance Company Name:** | **Policyholder Name:** |
| **Policy Number:** | **Policyholder DOB:** |
| **Secondary Insurance:** | **Secondary Insurance Policy #:** |

**Current Diagnoses and ICD code:**

**Reason for Referral (Why are they in need of services now?):**

**Is there anything else you’d like to let us know about this family?**

**Current Medication and Doses:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Prescriber:**  Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Collateral Contact Information**

**Primary Care Provider:**  \_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatrist:**  \_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Outpatient Therapist: \_\_\_\_** Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DCF or DMH Contact Person: \_\_\_\_\_** Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_⁯

**DYS or Probation Contact Person:**  \_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⁯

**School System:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Referring Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have any additional questions please contact: Alicia Straus, LICSW at 508-209-3471**

**or astraus@jri.org**