Metro Boston Community Based Services

REFERRAL FORM

Date of Referral:_____

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

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: _____ LGBTQ+: ☐ **Yes**

Ethnicity: _____ Race: _____ Allergies: _____

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

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

Current Medications: _____

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 (Street, City/Neighborhood, Zip): _____

Cell/Home Phone: _____ Email: _____

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

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:

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Reasons for Referral (please include any safety concerns):

Reason IHT Level of Care needed (*please check all that apply*):

☐ Outpatient services alone are not sufficient to meet youth/family's clinical needs
☐ Need for 24/7 urgent telephonic response management/safety planning
☐ Youth at risk for out of home placement
☐ Need for care coordination with school, other providers, state agencies, etc
☐ High level of risk factors
☐ Need treatment to enhance youth's problem-solving, limit-setting, and communication to sustain youth in the home
☐ Strengthen caregiver(s) ability to sustain youth in the home

For IHT referrals, what is the family work that is needed?

For TM referrals, what are some identified community skills youth would be working on?

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**	☐	☐	☐	_____

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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/Guardian Consent	_____
Date Services Started	_____