CHILDREN'S FRIEND & FAMILY SERVICES
A DIVISION OF JRI

**Date of Referral:** _____

**PLEASE ENSURE person/parent/guardian/caregiver voluntarily agrees to this service and referral**

| Please select location and service preference(s): | All ages: | | Youth Up to Age 21 (Eligibility based on Insurance plan coverage): | | | | |
|---|---|---|---|---|---|---|---|
| | Outpatient | Outpatient Groups | In Home Therapy | In Home Behavioral Service | Community Service Agency | Family Support & Training* | Therapeutic Mentoring* |
| ☐ Salem; Please fax: 978.740.9145 | ☐ | ☐ | ☐ | - | - | - | ☐ |
| ☐ Lynn; Please fax: 781.595.1081 | ☐ | ☐ | ☐ | - | ☐ | ☐ | ☐ |
| ☐ Gloucester; Please email Gloucester@jri.org | ☐ | ☐ | ☐ | - | - | - | ☐ |
| ☐ Lawrence; Please fax : 978.686.2954 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Chelmsford; 978.221.5831 | - | - | ☐ | ☐ | - | - | ☐ |

***TM & FS&T referral must come from Outpatient Therapist, IHT, ICC**

**Attach:** Comprehensive Assessment, CANS and Treatment/Individualized Action/Care Plan. **ICC:** ensure goal is entered into Provider Connect

## Person Being Referred Information:

**Preferred Language:** ☐English ☐Spanish ☐Other: _____

**Name:** _____ **D.O.B:** _____

**Address:** _____ **Home Telephone:** _____

**Cell Phone:** _____

**Primary Insurance:** _____ **Policy #:** _____

**Secondary Insurance:** _____ **Policy #:** _____

**Social Security #:** _____ **Email:** _____

**Racial ID (all that apply):** ☐ American Indian, Alaskan Native, or Indigenous North American ☐ Asian or Asian America ☐ Black or African American ☐ Latino/a/x or Hispanic ☐ Native Hawaiian or other Pacific Islander ☐ White or European American ☐ Multiracial ☐ Declined to Specify ☐ Not listed, please specify:_____

**Ethnic ID:** ☐ Latino/a/x or Hispanic ☐ Not Latino/a/x or Hispanic ☐ Declined to Specify

**Gender:** ☐ Cisgender Woman/Girl ☐ Cisgender Man/Boy ☐ Genderfluid ☐Genderqueer ☐ Non-Binary ☐ Transgender Man/Boy ☐Transgender Woman/Girl ☐ Declined to specify ☐ Not listed, please specify: _____

**PCP:** _____

**Allergies/Medical Conditions/Medications:**

**Best Times to Call/Scheduling Needs:**

## Parent/Guardian Information (☐*Check here if person is adult/own guardian and skip to next section)*:

**Preferred Language:** ☐English ☐Spanish ☐Other: _____

**Name:** _____ **Relationship to Child:** _____

**Address:** _____ **Email:** _____

**Cell Phone:** _____ **Other Telephone:** _____

**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:

**What School Does Youth Attend:**

**Person Making Referral:** *(☐Check here if self-referral)*:

| | | | |
|---|---|---|---|
| **Name and Role:** | | | |
| **Fax:** | | **Organization:** | |
| **Address:** | | **Work Phone:** | |
| **E-mail:** | | **Cell Phone:** | |

**Service Preferences:** *(Please note: we will accommodate based on clinical appropriateness and program capacity)*

| | |
|---|---|
| **Best Times/Days to be Seen:** | |
| **Preferred Place(s) to be Seen:** | ☐ Office ☐ School ☐ Home ☐ Telehealth ☐ Other: |

**Brief description of your concerns and goals in referring this person** *(please include any current safety concerns)*:

**Known Services/Agency Involvement:**

| | Past | Current | 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/Family Stabilization Team | ☐ | ☐ | ☐ | |
| ☐ 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: | ☐ | ☐ | ☐ | |

**History of Psychiatric Diagnosis:**

**Please list any known diagnosis (required for TM/FST referrals):**

**Risk Factors:** ☐DV ☐Mental Illness ☐Substance Use ☐Abuse ☐Neglect ☐Medical Issues ☐Cultural Factors ☐Suicidal/Homicidal Ideation
☐ Psychiatric ER visit or screened in last 6 months ☐ History of Psychiatric hospitalization ☐ Other

**Accepted insurances for JRI: (eligibility based on plan coverage)**

Allways Health Partners My Care Family (Mass Health) • Allways Commerical • Beacon /Fallon (Commercial) Beacon/Boston Medical HealthNet Plan (Commercial) • Beacon/Boston Medical HealthNet Plan (Mass Health) Beacon/ Fallon (Mass Health) • Blue Cross Blue Shield of MASS • GIC Unicare (Commercial) • Harvard Pilgrim MBHP/Massachusetts Behavioral Health Partnership • Medicaid • Medicare • United Healthcare United Behavioral Health • Tufts Public Health Plan (Mass Health)