



**Justice Resource Institute, Inc.
Pioneer Valley Community Based Services**

476 Appleton Street #5 Holyoke, MA 01040
Phone (978) 799-7397 Fax (413) 322-0496

Please select service being sought: In-Home Therapy Therapeutic Mentoring

For **In-Home Therapy** or **Therapeutic Mentoring** services we accept Massachusetts Behavioral Health Partnership, HNE Be Healthy, Beacon and Tufts Health Together MassHealth insurance plans as well select Blue Cross Blue Shield plans. IHT and TM services available through age 21.

Please note: Therapeutic Mentoring referrals are only accepted from the youth's Outpatient Therapist, In Home Therapist or Intensive Care Coordinator, and must include a copy of the most recent CANS, Comprehensive Assessment, the child's safety plan and current Treatment Plan/Care Plan including TM treatment objectives.

**Once completed, please FAX or EMAIL referral form to:
Morganne Crouser at 413-322-0496 or mcrouser@jri.org.**

Person Being Referred Information:

Preferred Name:

Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Legal Name: _____	D.O.B.: _____
Address: _____	Home Telephone: _____
	Cell Phone: _____
Primary Insurance: _____	Policy #: _____
Secondary Insurance: _____	Policy #: _____
Preferred Pronouns: _____	Email: _____
Racial ID <input type="checkbox"/> American Indian, Alaskan Native, or Indigenous North American <input type="checkbox"/> Asian or Asian America (all that apply): <input type="checkbox"/> Black or African American <input type="checkbox"/> Latino/a/x or Hispanic <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White or European American <input type="checkbox"/> Multiracial <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Not listed, please specify: _____	
Ethnic ID: <input type="checkbox"/> Latino/a/x or Hispanic <input type="checkbox"/> Not Latino/a/x or Hispanic <input type="checkbox"/> Declined to Specify	
Gender: <input type="checkbox"/> Cisgender Woman/Girl <input type="checkbox"/> Cisgender Man/Boy <input type="checkbox"/> Genderfluid <input type="checkbox"/> Genderqueer <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender Man/Boy <input type="checkbox"/> Transgender Woman/Girl <input type="checkbox"/> Declined to specify <input type="checkbox"/> Not listed, please specify: _____	
PCP: _____	
Allergies/Medical Conditions/Medications: _____	
Best Times to Call/Scheduling Needs: _____	Can leave messages on Home phone? Cell phone?

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

Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Name: _____	Relationship to Child: _____
Address: _____	Home Telephone: _____
Cell Phone: _____	Other Telephone: _____
Legal Guardian (<input type="checkbox"/> same as above): _____	
Physical Custody: (<input type="checkbox"/> same as above): _____	
Where does child currently live? <input type="checkbox"/> With Parent(s)/Guardian(s) <input type="checkbox"/> Foster Home <input type="checkbox"/> Group Home <input type="checkbox"/> Other:	
What school & grade does youth attend:	
Is youth on a 504 Plan / IEP?:	

Person Making Referral: (Check here if self-referral) (Check here if parent/caregiver is aware of 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: <input type="checkbox"/> Office <input type="checkbox"/> School <input type="checkbox"/> Home <input type="checkbox"/> Telehealth <input type="checkbox"/> Other:

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

Known Services/Agency Involvement:

	Current	Closed within past 30 days	History	Contact Person and Telephone and/or e-mail
<input type="checkbox"/> Department of Children and Families (DCF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Department of Mental Health (DMH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Department of Youth Services (DYS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Child Requiring Assistance (CRA)/Court	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> In Home Therapy/Family Stabilization Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Therapeutic Mentoring/Other Mentoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> In-Home Behavioral Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Therapy/Counseling/Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Psychopharmacology/Psychiatry Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> ER visit or screened in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

History of Psychiatric Diagnosis:

Please list any known diagnosis (required for TM/FST referrals):
Risk Factors: <input type="checkbox"/> DV <input type="checkbox"/> Mental Illness <input type="checkbox"/> Substance Use <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Medical Issues <input type="checkbox"/> Cultural Factors <input type="checkbox"/> Suicidal/Homicidal Ideation <input type="checkbox"/> Psychiatric ER visit or screened in last 6 months <input type="checkbox"/> History of Psychiatric hospitalization <input type="checkbox"/> Other:
Strengths:

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)