Justice Resource Institute, Inc.
Pioneer Valley Community Based Services
476 Appleton Street #5 Holyoke, MA 01040
Phone (978) 799-7397 Fax (413) 322-0496

INSTRUCTIONS: Please fill out this referral form as completely as possible.

Justice Resource Institute's Pioneer Valley Community Based Services provides Children's Behavioral Health Initiative **In-Home Therapy** and **Therapeutic Mentoring** services for youth and families experiencing social, emotional, behavioral, or functional challenges.

In-Home Therapy (IHT) is intensive family therapy provided by a team of two behavioral health staff to help youth with social, emotional, or behavioral challenges.
– *Typical frequency*: 1–3 sessions per week that occur at home or in the community
– *Who can benefit*: Families of youth with moderate to severe behavioral health symptoms who want help to resolve conflicts, learn new ways to talk to and understand each other, create new helpful routines, and find community resources

Therapeutic Mentoring (TM) pairs a youth with an adult mentor to help the youth build and improve their social, communication, and life needs.
– *Typical frequency*: Weekly sessions at home or in the community
– *Who can benefit*: Youth who have moderate to severe behavioral health symptoms and who need support in the areas of problem-solving, social skills, communication, or conflict resolution.
To receive TM, the youth also need to be receiving another behavioral health service (outpatient, IHT, IHBS, ICC or FIT).

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

Referral for: ☐ **In Home Therapy** ☐ **Therapeutic Mentoring** TM referrals must include the most recent Treatment Plan, CANS, Comprehensive Assessment, and Safety Plan from Hub provider.

Youth's Legal Name: _____ Date of Birth: _____

Chosen Name/Nickname: _____ Race/Ethnicity: _____ Age: _____

Gender Identity: _____ Pronouns: _____ Grade in School: _____

Address: _____ Zip: _____

Preferred Language: _____ Other Languages Spoken: _____

Accommodations Required: _____ ☐ Not Applicable

School: _____ IEP/504 Plan? ☐ yes ☐ no

Caregiver's Name(s): _____ Relationship to Youth: _____

Who has the right to make medical and legal decisions for the youth? _____

Preferred Contact: ☐ phone ☐ email ☐ text Email: _____

Phone: _____ Alt Phone: _____
Okay to leave message? ☐ yes ☐ no Okay to leave message? ☐ yes ☐ no

Address: _____ Zip: _____

Preferred Language: _____ Other Languages Spoken: _____

Is the youth in DCF custody? ☐ yes ☐ no Are there any outstanding 51A's? ☐ yes ☐ no

Referral Source's Name: _____ Relationship to Youth: _____

Referring Agency:_____ Phone: _____

Email: _____ Fax: _____

Please include signed Release of Information with Referral if Applicable

Is the family aware of this referral to services? ☐ yes ☐ no

Primary Insurance: _____ MMIS:_____

Subscriber Name: _____ Subscriber ID: _____

Secondary Insurance: _____

Subscriber Name: _____ Subscriber ID: _____

Primary Care Physician: _____ PCP Phone: _____

Medical Conditions/Allergies: _____

Provide a brief description of your goals, safety concerns, diagnosis, and/or other needs in making referral:

_____

_____

_____

Risk Factors:(Domestic violence, suicidal ideation/intent, homicidal ideation/intent, substance use, trauma, etc.)

_____

_____

_____

Has the youth received any of the following services in the last 30 days?

☐Inpatient Psychiatric ☐CBAT/ICBAT ☐Community Crisis Stabilization ☐Mobile Crisis Intervention
☐Other: _____

Current Providers or State Agency Involvement: ☐DCF ☐DMH ☐DYS ☐School ☐Outpatient
☐Not Applicable ☐Other:_____

Provider: _____ Type: _____ Phone: _____

Provider: _____ Type: _____ Phone: _____

Provider: _____ Type: _____ Phone: _____

Provider: _____ Type: _____ Phone: _____

Provider: _____ Type: _____ Phone: _____

Signature of Referral Source: _____ **Referral Date**: _____