Children's Friend and Family Services
Referral – Community Service Agency (CSA)

Date of Referral: _______________

☐ **Lynn:** 112 Market Street, 2nd Fl
p: 781.593.7676
Please fax to: 781.595.1081

☐ **Lawrence:** 15 Union St, Ste. 200
p: 978.682.7289
Please fax to: 978.686.2954

Eligibility Criteria: (Each must be met for youth to qualify for CSA Services. Please Check all that Apply)

☐ The child/youth is under 21 and has Mass Health; MBHP, Network Health, Neighborhood Health Plan, BMC HealthNet, or Fallon.
☐ Child/youth currently has or has had a diagnosable mental, behavioral or emotional disorder that has caused functional impairment that limits youth's functioning in family, school, or community activities.
☐ The emotional difficulty is not solely the result of autism or a developmental disorder.
☐ The family has been informed about CSA services (Intensive Care Coordination and Family Support and Training) and are willing to participate voluntarily.

Child/Youth Information: Preferred Language: ☐English ☐Spanish ☐Other: ________

Name: ________ **D.O.B:** ________
School: ________ **Grade:** ________ **IEP?** ☐Yes ☐No
Primary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** ________
Secondary Insurance: ☐ MBHP ☐ Network Health ☐ Neighborhood Health Plan ☐ BMC HealthNet ☐Other: **Policy #:** ________
Ethnicity: ________ **Gender:** ☐Male ☐Female **SS#:** ________
Psychiatric Diagnosis*: **DSM Code:** ________ **Narrative:** ________
DSM Code: ________ **Narrative:** ________
Who generated dx and when? ________ **PCP:** ________

Including this information significantly assists in ability to gain authorization for service. Please include when at all possible.

Medical Conditions/Allergies/Medications:

Parent/Guardian Information: Preferred Language: ☐English ☐Spanish ☐Other: ________

Name: ________ **Ethnicity:** ________
Relationship to Child: ________
Address: ________ **Home Telephone:** ________
Cell Phone: ________ **Other Telephone:** ________
Best Times to Call/Scheduling Needs: ________
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:

If not with parent(s)/guardian(s) listed above, please give name, address, and telephone number of current residence:

Person Making Referral: **Fax:** ________
Name: ________ **Organization/Agency:** ________
Address: ________ **Work Telephone:** ________
E-mail: ________ **Cell Phone:** ________
Check Level of Care if Applicable: ☐N/A ☐ CSA ☐ IHT ☐ Outpatient ☐ ESP/MCI ☐ CBAT ☐ STARR ☐ Hospital ☐ Other:

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 Involvement	☐	☐	☐	
☐In Home Therapy/Family Stabilization Team (FST)	☐	☐	☐	
☐Therapeutic Mentoring/Other Mentoring	☐	☐	☐	
☐In-Home Behavioral Services	☐	☐	☐	
☐Therapy/Counseling/Outpatient Services	☐	☐	☐	
☐Psychopharmacology/Psychiatry Services	☐	☐	☐	
☐Hospitalized	☐	☐	☐	
☐Emergency Room visit or screened in last six months	☐	☐	☐	
☐Other:	☐	☐	☐	

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

Past/Current Risk Factors: ☐DV ☐Mental Illness ☐Substance Use Disorder ☐Abuse ☐Neglect ☐Medical Issues ☐Cultural Factors ☐Suicidal/Homicidal Ideation ☐ Other: