

Children's Friend and Family Services Referral – Family Support & Training (FS&T)

Date of Referral: _____

<input type="checkbox"/> Lynn: 112 Market Street, 2nd Fl, Lynn p: 781.593.7676 Please fax to: 781.595.1081	<input type="checkbox"/> Lawrence: 15 Union St, Ste. 200, Lawrence p: 978.682.7289 Please fax to: 978.686.2954
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Eligibility Criteria: (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.

Youth is currently actively enrolled and participating in Outpatient Therapy, In-Home Therapy, or Intensive Care Coordination through a Community Service Agency

FS&T services have been explained to the youth and family and the youth and parent/caregiver gives consent and agrees to participate.

A Comprehensive Assessment and CANS have been completed for this youth – PLEASE ATTACH

A Treatment Plan/Individualized Action Plan/Care Plan has been completed for this youth and includes a specific goal with objective outcome measures pertaining to the development of the parent/caregiver capacity to parent the youth in the home or community – PLEASE ATTACH

The youth resides with or has current plans to return to the identified parent/caregiver.

Child/Youth Information: Preferred Language: English Spanish Other: _____

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

School: _____ **Grade:** _____ **IEP?** _____

Primary Insurance: MBHP Network Health Neighborhood Health Plan **Policy #:** _____
 BMC HealthNet Other: _____

Secondary Insurance: MBHP Network Health Neighborhood Health Plan **Policy #:** _____
 BMC HealthNet Other: _____

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
<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 Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> In Home Therapy/Family Stabilization Team (FST)	<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"/> Emergency Room visit or screened in last six months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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: