Children's Friend and Family Services
Referral – In-Home Therapy

Date of Referral: _____

☐ **Salem:**	☐ **Lynn:**	☐ **Gloucester:**
110 Boston St, Salem	112 Market Street, 2nd Fl,Lynn	33 Commercial St, Gloucester
p: 978.744.7905	p: 781.593.7676	p: 978.283.7198
Please fax to: 978.740.9145	**Please fax to: 781.595.1081**	**Please fax to: 978.281.7793**

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 has a parent/guardian/caregiver who voluntarily agrees to participate in this service and agrees to provide consent.
☐ Outpatient services alone are not sufficient to meet the youth's needs for coaching, support, and education.
☐ If a Comprehensive Assessment and CANS have been completed, please forward with this referral.

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

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

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

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: