Children's Friend and Family Services
Referral – Therapeutic Mentoring

Date of Referral: ________________

☐ **Salem:**	☐ **Lynn:**	☐ **Gloucester:**	☐ **Lawrence:**
110 Boston St, Salem	112 Market Street, 2nd Fl, Lynn	33 Commercial St, Gloucester	15 Union St, Ste. 200, Lawrence
p: 978.744.7905	p: 781.593.7676	p: 978.283.7198	p: 978.682.7289
Please fax to: 978.740.9145	**Please fax to: 781.595.1081**	**Please fax to: 978.281.7793**	**Please fax to: 978.686.2954**

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
☐ TM services have been explained to the youth and family and the youth and family voluntarily agree to the service.
☐ 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 for mentoring – PLEASE ATTACH
☐ If ICC is the hub, TM goal has been entered into Provider Connect.

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: