

COMMUNITY SERVICE AGENCY REFERRAL

Northeast Behavioral Health

<p>Community Service Agency – Haverhill Area Intensive Care Coordination & Family Support and Training Northeast Behavioral Health (formerly Health & Education Services, Inc.) 8-10 Howard St. Haverhill, MA 01830 Phone: 978-374-0414</p>	<p>Fax - in Referral Form Fax: 978-374-7615</p>																						
<p>Referral Procedure: Please call us anytime to discuss the referral or other related issues.</p> <ol style="list-style-type: none"> 1. Please discuss the referral with the child and his/her parent(s)/guardian(s) 2. Once the referral is received, the family will: <ul style="list-style-type: none"> • Be contacted within 3 days • Receive an explanation/overview of the program • Be offered a home visit 3. We will consult with the family about their needs and different services that are available. If enrolled we will complete an assessment within 10 days and contact the referring party. If the child is ineligible, or the program is not appropriate for the child, we will assist the family with other community referrals. 	<p>Eligibility Criteria: (Please Check all that Apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> The child is under the age of 21. <input type="checkbox"/> The child currently has or has had in the past a diagnosable mental, behavioral, or emotional disorder. <input type="checkbox"/> The disorder causes/caused functional impairment that limits the youth's functioning in family, school or community activities. <input type="checkbox"/> The emotional difficulty is not solely the result of autism or a developmental disorder. <input type="checkbox"/> The child in an enrolled member with Masshealth or eligible to be enrolled in Masshealth Standard or Masshealth Commonwealth? <input type="checkbox"/> The family has been informed about Intensive Care Coordination (ICC) and Family Support and Training and is willing to participate voluntarily. 																						
<p>Child Information: Name: _____ D.O.B.: _____ Mass Health or SS #: _____ Ethnicity: _____ Gender <input type="checkbox"/> Male <input type="checkbox"/> Female School: _____ Grade: _____ Child has Individualized Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Diagnosis: _____ Psychiatric Medications: _____</p>	<p>Parent/Guardian Information: Name: _____ Ethnicity: _____ Relationship to Child: _____ Address: _____</p>																						
<p>Medical Conditions: _____ Medications: _____</p>	<p>Home Telephone: _____ Work Telephone: _____ Cellular Telephone: _____ Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish <input type="checkbox"/> Other:</p>																						
<p>Known Services/Agency Involvement (please check all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Department of Children and Families (DCF)</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Department of Developmental Disabilities (DDS)</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Department of Mental Health (DMH)</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Department of Youth Services (DYS)</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Child In Need of Services (CHINS)/Court Involvement</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> In Home Therapy/Family Stabilization Team (FST)</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Mentoring</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> In-Home Behavioral Services</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Therapy/Counseling</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Psychopharmacology/Psychiatry Services</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td><input type="checkbox"/> Past <input type="checkbox"/> Current</td> </tr> </table>	<input type="checkbox"/> Department of Children and Families (DCF)	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Department of Developmental Disabilities (DDS)	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Department of Mental Health (DMH)	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Department of Youth Services (DYS)	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Child In Need of Services (CHINS)/Court Involvement	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> In Home Therapy/Family Stabilization Team (FST)	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Mentoring	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> In-Home Behavioral Services	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Therapy/Counseling	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Psychopharmacology/Psychiatry Services	<input type="checkbox"/> Past <input type="checkbox"/> Current	<input type="checkbox"/> Other:	<input type="checkbox"/> Past <input type="checkbox"/> Current	<p>Legal Guardian (<input type="checkbox"/> same as above): _____ Physical Custody: (<input type="checkbox"/> same as above): _____</p> <p>Where does child currently live? <input type="checkbox"/> With Parent(s)/Guardian(s) <input type="checkbox"/> Foster Home <input type="checkbox"/> Group Home <input type="checkbox"/> DYS Facility <input type="checkbox"/> Inpatient <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Other: <i>If not with parent(s)/guardian(s) listed above, please give name, address, and telephone number of current residence:</i></p> <p>Hospitalized in past year <input type="checkbox"/> Yes <input type="checkbox"/> No Emergency Room visit or screened in last six months <input type="checkbox"/> Yes <input type="checkbox"/> No Previously placed outside of the home <input type="checkbox"/> Yes <input type="checkbox"/> No Current risk of out of home placement <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Brief description of your concerns and goals in referring child:</p>	<p>Person Making Referral: Name: _____ Organization: _____ Address: _____ Work Telephone: _____ Cellular/Other Telephone: _____ Pager Number: _____ E-mail: _____</p>																						

<p>CSA Staff Use Only: Staff assigned for follow up: _____ Date Referral Received: _____</p>	<p>Ongoing Staff Assigned: Family Partner: _____ Intensive Care Coordinator: _____ Date of Initial Appointment Offered: _____</p>
<p><input type="checkbox"/> Logged in Excel <input type="checkbox"/> PA/EVS <input type="checkbox"/> Authorization</p>	