THERAPEUTIC MENTORING REFERRAL
Northeast Behavioral Health

☐ Cape Ann/Beverly: 800 Cummings Center, Suite 266T Beverly, MA 01915/ Fax: 978-922-0098/Tel: 978-998-3680
☐ Lawrence: 12 Methuen St., Lawrence, MA 01841/Fax: 978-682-7296/Tel: 978683-3128
☐ Haverhill: 60 Merrimack St., Haverhill, MA 01830/Fax: 978-373-6363/Tel: 978-373-1126

Eligibility Criteria:

- The child is an enrolled member with MassHealth
- The child is under the age of 21
- A comprehensive behavioral health assessment including the Massachusetts Child and Adolescent Needs and Strengths (CANS) indicates that the youth's clinical condition warrants this service
- Outpatient services alone are not sufficient to meet the youth's needs for coaching, support, and education.
- The youth is currently engaged in outpatient services, In-Home Therapy, or Intensive Care Coordination (ICC) through a Community Service Agency and the provider or the ICC Care Planning Team determine that Therapeutic Mentoring Services can facilitate the attainment of a goal or objective identified in the treatment plan/Individualized Care Plan that pertains to the development of communication skills, social skills, and peer relationships.

Referral procedure – Referral Source (The In-Home Therapy, Outpatient, or Intensive Care Coordination Provider) Must:

☐ Discuss the referral with the youth and his/her parent(s)/guardian(s)
☐ Complete the information below to determine eligibility and to communicate reasons for referral and identified goals for Therapeutic Mentoring per ICC Individualized Care Plan or Outpatient/In-Home Treatment Plan**. (IF CSA IS HUB: ICC MUST ENSURE MENTORING HAS BEEN ENTERED INTO PROVIDER CONNECT AND UNITS HAVE BEEN ALLOCATED FOR TM. IF NETWORK HEALTH, ICC MUST CALL AND OBTAIN AUTHORIZATION).**
☐ **ATTACH** a copy of your most recently completed ***Assessment*** including the Massachusetts Child and Adolescent Needs and Strengths (CANS) indicating that the youth's clinical condition warrants this service.
☐ **ATTACH** a copy of current ***Care Plan/Treatment Plan/Individualized Action Plan*** with a clear goal specified for Therapeutic Mentoring. The goal should relate to building specific skills in a community environment.

Youth's Name: ____________ **MIS:** ________ **D.O.B:** ________ **Gender:** ☐Male ☐Female
Insurance Type: ☐MBHP ☐Network Health ☐Beacon (NHP,Health Net, FCHP) **Policy #:** ________
Ethnicity: ____________ **Primary Language:** ☐English ☐Spanish ☐Other:
Axis I Code (Primary): ________ **Narrative:** ____________
Axis I Code (Secondary): ________ **Narrative:** ____________

Known Services/Agency Involvement (please check all that apply and indicate if past or current):

☐Department of Children and Families (DCF)
☐Department of Developmental Disabilities (DDS)
☐Department of Mental Health (DMH)
☐Department of Youth Services (DYS)
☐Child In Need of Services (CHINS)/Court Involvement
☐In Home Therapy/Family Stabilization Team (FST)
☐Mentoring
☐In-Home Behavioral Services
☐Therapy/Counseling
☐Psychopharmacology/Psychiatry Services
☐Other:
☐Other:

Youth Lives at: ☐Home ☐Foster Home ☐Residential Placement ☐Other: ________
Address: ____________
Legal Guardian: ☐Parent(s) ☐DCF ☐Other: ________
Parent(s)/Guardian(s) Name(s): ____________
Telephone (Home): **Telephone (Cell/Other):**

Person Making Referral: ____________ **Relationship to Youth:** ________
Organization: ____________ **Address:** ________
Work Telephone: ____________ **Cell./Other Telephone:** ________
E-mail: ____________ **Date of Referral:** ________
Mentor Preference: ☐Male ☐Female ☐Either **Days/Times Youth is Available for Mentoring:** ________
Reasons for referral and identified goals (check all that apply):
☐ Requires education, support, coaching, and guidance in age-appropriate behaviors, interpersonal communication, problem solving and conflict resolution,and relating appropriately to others.
☐ Requires support in transitioning back to the home, foster home, or community from a congregate care setting
☐ Other:

TM Staff Use Only:
Date Referral Received: ____________ **Therapeutic Mentor Assigned:**
☐Logged ☐PA/EVS ☐Authorization