Lahey Health Behavioral Services

COMMUNITY SERVICE AGENCY REFERRAL

Community Service Agency – Cape Ann/Salem

Lahey Health Behavioral Services
800 Cummings Center, Suite 360-U
Beverly, MA 01915
(978) 922-0025

Fax - in Referral Form

Fax: 978-922-0098

Referral Procedure:
Please call us anytime to discuss the referral or other related issues.

1. **Please discuss the referral with the child and his/her parent(s)/guardian(s)**

2. Once the referral is received, the family will:
   - 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.

Eligibility Criteria: (Please Check all that Apply)

- ☐ The child is under the age of 21.
- ☐ The child currently has or has had in the past a diagnosable mental, behavioral, or emotional disorder.
- ☐ The disorder causes/caused functional impairment that limits the youth's functioning in family, school or community activities.
- ☐ The emotional difficulty is not solely the result of autism or a developmental disorder.
- ☐ The child in an enrolled member with MassHealth or eligible to be enrolled in MassHealth Standard or MassHealth Commonwealth?
- ☐ The family has been informed about Intensive Care Coordination (ICC) and Family Support and Training and is willing to participate voluntarily.

Child Information:

Name: _____ **D.O.B:** _____
Mass Health or SS #: _____
Ethnicity: _____ **Gender** ☐Male ☐Female
School: _____ **Grade:** _____
Child has Individualized Education Plan (IEP)? ☐Yes ☐No
Psychiatric Diagnosis: _____
Psychiatric Medications:

Medical Conditions: _____
Medications:

Known Services/Agency Involvement (please check all that apply):

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

Brief description of your concerns and goals in referring child:

Parent/Guardian Information:

Name: _____ **Ethnicity:** _____
Relationship to Child: _____
Address:

Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____
Preferred Language: ☐English ☐Portuguese ☐Spanish ☐Other:

Legal Guardian (☐same as above**):** _____
Physical Custody: (☐same as above**):** _____

Where does child currently live?
☐With Parent(s)/Guardian(s) ☐Foster Home ☐Group Home
☐DYS Facility ☐Inpatient ☐Residential Treatment
☐Other:
If not with parent(s)/guardian(s) listed above, please give name, address, and telephone number of current residence:

Hospitalized in past year	☐Yes	☐No
Emergency Room visit or screened in last six months	☐Yes	☐No
Previously placed outside of the home	☐Yes	☐No
Current risk of out of home placement	☐Yes	☐No

Person Making Referral:

Name: _____
Organization: _____
Address: _____
Work Telephone: _____
Cellular/Other Telephone: _____
FAX : _____
E-mail: _____

CSA Staff Use Only:

Date Referral Received:		**MIS#:**	
Diagnosis:		**ICC Assigned:**	
Active in AR Plus?		**Family Partner:**	

In the Record, place directly following divider for Section 2, Clinical.