CENTRO | 11 Sycamore Street | Worcester, MA 01608 | centroinc.org | 508.798.1900

CHILDREN'S BEHAVIORAL HEALTH INITIATIVE

In Home Therapy Referral

REFERRAL SOURCE		
☐ Parent/Guardian ☐ School ☐ DCF ☐ PCP ☐ Other_____		
Date	**Agency/Program**	
Name	**E-Mail**	**Phone Number**

Member Information (Youth being referred)			
Insurance:		**MMIS #:**	
Complete Name		**DOB**	**Gender**
Guardian	**Relationship**	**Phone Number**	
Address	**Town**	**Zip Code**	

Preferred Language: ☐ English ☐ Spanish ☐ Portuguese ☐ Other _____

Family Availability/Times:_____

Current/Past Diagnosis: _____

Current Medications: _____

Other Services in the Home (DCF/DDS): _____

_____

Reason IHT Level of Care needed (please check all that apply):

☐ Outpatient services alone are not sufficient to meet youth and family's needs for clinical intervention

☐ Need for care coordination with school, other providers, and family's needs for clinical intervention state agencies, natural supports, etc.

☐ Need for increased frequency/duration/flexibility of family session depending on need in the home and community

☐ High level of risk factors (indicate below)

☐ Youth at risk for out-of-home placement

☐ Need treatment to enhance youth's problem-solving, management/safety planning limit setting, and communication to sustain youth in home

☐ Strengthen caregiver(s) ability to sustain youth in home

Youth At-Risk Factors or Safety Concerns (* explain below)

☐ Suicidal Ideations/Gestures ☐ Homicidal Ideations/Gestures ☐ Substance Use
☐ Aggressive Behaviors ☐ Run-away Behaviors ☐ Gang-Involvement
☐ School Refusal ☐ Sexual Promiscuity ☐ Isolates
☐ Medical/Physical ☐ Trauma History ☐ Not Med-compliant

Caregiver At-Risk Factors or Safety Concerns ☐ NONE

☐ Current or History Substance Abuse ☐ Housing instability ☐ Domestic Violence
☐ Financial Distress ☐ Mental Health Diagnosis ☐ Lack of natural supports

Safety Concerns ☐ NONE

☐ Unsafe Neighborhood ☐ Current Domestic Violence ☐ Violent Family Member
☐ Pets_____ ☐ Suspected Substance Abuse ☐ Weapons in Home

Reason for Referral (explain symptoms and need for services) **:**

Please Note that all of the following criteria are necessary for participation in this level of care:

- A comprehensive behavioral health assessment inclusive of the MA Child and Adolescent Needs and Strengths indicates that the youth's clinical condition warrants this service in order to enhance problem-solving, limit-setting, and risk management/safety planning and communication; to advance therapeutic goals or improve ineffective patterns of interaction; and to build skills to strengthen the parent/caregiver's ability to sustain the youth in their home setting or to prevent the need for more-intensive levels of service such as inpatient hospitalization or other out-of-home behavioral health treatment services.
- The youth resides in a family home environment (e.g., foster, adoptive, birth, kinship) and has a parent/guardian/caregiver who voluntarily agrees to participate in In-Home Therapy Services.
- Outpatient services alone are not or would not likely be sufficient to meet the youth and family's needs for clinical intervention/treatment.
- Required consent is obtained. The service needs identified in the treatment plan/ care plan are being fully met by similar services The youth is placed in a residential treatment setting with no plans for return to a home setting

Visit masspartnership.com for more information

To Complete Referral:
Fax form and attachments: 508-798-1914
Scan and email: cbhireferrals@centroinc.org

CBHI STAFF USE ONLY	
Assigned to	**Date**