COMMUNITY SERVICE AGENCY (CSA) REFERRAL FORM

Please call, fax, email, or place in CSA's mailbox.

CSA Referral Line: (508) 828-9112 press 5 **Fax: (508) 824-0111**

If you have questions, please contact Kelley Mann, LICSW, Program Director for CSA at (508) 977-8135/ kmann@comcounseling.org

Please note: All referrals will be responded to within 24 hours. If this referral is placed after 5 pm Friday or during the weekend, please be sure to leave a message on the referral line at (508) 828-9112, press 5.

Complete all fields fully, including entire address with zip code, insurance and referral source. Incomplete referral forms could delay processing.

Please indicate the CSA service you would like to make a referral for: (*Any person or provider can make a referral for the following services.*)

☐ **INTENSIVE CARE COORDINATION (ICC)** ☐ **INTENSIVE CARE COORDINATION AND FAMILY PARTNER (ICC and FP)**

☐ **FAMILY PARTNER (FP)** – If requesting **just** the Family Partner service, the referral must come from an outpatient therapist, ICC or In Home Therapy (IHT) provider. Please provide CANS, Comprehensive Assessment and Treatment plan with FP goals written into the plan.

NAME OF ENROLLING CHILD: ______________________ DOB: __________ Age (Birth-21) ________ Gender: _____

CAREGIVER NAME /PLACEMENT OF CHILD: ______________________
Address: ______________________ Town: ______________ Zip Code: ____________
Telephone(s): ______________________

Massheatlh Insurances Accepted: (Please check type of insurance and supply correct insurance number.)
☐ MBHP ☐ WellSense ☐ Mass General ☐ Tufts MMIS (Insurance) Number: ______________________

Commercial Insurances Accepted: (Please check type of insurance and supply correct insurance number.)
☐ Tufts ☐ Blue Cross/Blue Shield of MA ☐ Other: ______________________
Insurance Card Number: ______________________

LEGAL GUARDIAN: ______________________ Relationship to Child: ______________________
Guardian's Telephone: ______________________ Guardian's Location: ______________________

FAMILY'S AVAILABILITY: ☐ Days ☐ Evenings ☐ Saturdays ☐ Times of Day: ______________________
(Please note, CSA hours of operation are Monday–Friday, 8am–8pm. However, we do try to accommodate a family's scheduling needs.)

AGENCIES/PERSONS WHO SHOULD BE CONTACTED REGARDING REFERRAL: (Include existing providers with telephone numbers)
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REFERRAL SOURCE: ______________________ Telephone: ______________________
If a self-referral, how did the Family hear about us? ______________________

MEMBERS OF HOUSEHOLD: (In addition to referred child)
Name: ______________________ DOB: ____________ Age: ________ Rel. to Child: ____________
Name: ______________________ DOB: ____________ Age: ________ Rel. to Child: ____________
Name: ______________________ DOB: ____________ Age: ________ Rel. to Child: ____________

CURRENT DIAGNOSIS: ______________________

CURRENT MEDICATIONS: (And dose, if known) ______________________

BEHAVIORAL PROBLEMS/AREAS OF CONCERN: (Please note any safety issues)
☐ Aggression ☐ Self-Harming Behaviors ☐ Fire Setting ☐ Running Away ☐ Concerns within educational setting
☐ Substance Use ☐ Sexualized Behaviors ☐ Gang Involved ☐ Emotional Regulation ☐ Managing Mental Health Needs

Are there any needs within the following areas?
☐ Parenting Skills ☐ Community Resources ☐ Support Navigating the IEP System ☐ Other

SAFETY ISSUES IN HOME AND/OR COMMUNITY THAT WE SHOULD BE AWARE OF:
☐ Domestic Violence ☐ Access to weapons ☐ Violence towards others ☐ Other: ______________________
☐ Animals (kinds of pets and how many): ______________________