CCBC
COMMUNITY COUNSELING
OF BRISTOL COUNTY, INC.
BEHAVIORAL HEALTHCARE SOLUTIONS

Therapeutic Mentoring (TM) Referral Form

Please complete both pages.
Note that incomplete information may delay service delivery.

Date of Referral: _____

Youth Name: _____ **Gender:**_____ **DOB:**_____ **Age** (Birth-21)**:**_____
MassHealth ID#: _____ **Ethnicity:** _____**Phone Numbers:** _____
_____

Indicate MassHealth Payer Type: ***Family Assistance Not Accepted****
1) MBHP 2) BMC (Beacon) 3) NHP (Beacon) 4) Network Health

Guardian(s) Name: _____ **Relationship to Child**_____
Parent Name (if different): _____
Address: _____ **Town:** _____ **Zip Code:** _____
Members of Household: _____

DCF Worker: _____ **Phone:** _____***Please identify if DCF custody:* CRA or Legal**

Has a TM referral been placed to another agency at the same time? If yes, which agencies? _____

Has the client received TM services previously? If yes, which agency? _____ **Mentor**_____

Check if Primary	ICD-10 Code	**DSM-IV/DSM 5 Narrative Description** (i.e. Major depressive disorder, single episode, moderate)

Medications:

Name	Dose	Frequency	Indication	Name	Dose	Frequency	Indication
1.				3.			
2.				4.			

Family's Preference for Scheduling: ***(please circle)*** **Weekday Weekend Either**
Details regarding availability: _____

Clinical Hub Referral Source: (*Required at time of referral in order to obtain authorization and provide services to youth.)
TM is a *Hub-Dependent* service, which means the hub is responsible for including TM services on care/treatment plan, updating document quarterly, and maintaining a minimum of weekly phone contact with assigned TM.

___**ICC Name:**_____ **Phone:** _____ **Agency:** _____
Please complete the following steps at time of referral to ensure timely outreach:

☐ Care plan and/or units have been submitted and authorized ☐ Attach Updated care plan with TM goal(s)

☐ Attach Current CANS ☐ Attach Updated safety plan

___**IHT Name:**_____ **Phone:** _____ **Agency:** _____
Please complete the following steps at time of referral to ensure timely outreach:

☐ Attach Updated treatment plan with TM goal(s) ☐ Attach Current CANS

☐ Attach comprehensive assessment ☐ Attach Updated safety plan

___**Outpatient Name:** _____ **Phone:** _____ **Agency:** _____
Please complete the following steps at time of referral to ensure timely outreach:

☐ Attach Updated treatment plan with TM goal(s) ☐ Attach Current CANS ☐ Attach comprehensive assessment

--Form Continues Onto Next Page--

Please identify one or more of these skill building categories to be included on the updated treatment plan/care plan with descriptive goals that include TM interventions *(please circle)*:

Socialization Skills Daily Living Skills Problem Solving Skills Conflict Resolution

Anger Management Skills Behavior Management Skills Self- Management Skills

At-Risk Factors or Safety Concerns Present *(please check all that apply)*:

☐ Suicidal Ideations ☐ Suicidal Gestures ☐ Self-Injurious Behavior ☐ Homicidal Ideations

☐ Current Substance Use ☐ Hx of Substance Abuse ☐ Runs away ☐ Violence/Aggression towards others

☐ Lack of social group ☐ Gang Involvement ☐ Sexualized Aggression/Behavior ☐ Fire-Setting

☐ Takes dangerous risks ☐ School refusal ☐ Sexual Promiscuity ☐ Isolates ☐ Not med compliant

☐ Trauma History, *please explain*: _____

☐ Medical/Physical Issues, *please explain*: _____

☐ Other: _____

Safety Concerns for Home-Based Mentor to Plan For *(please check all that apply)*:

☐ Unsafe Neighborhood ☐ Current Domestic Violence ☐ Violent Family Member or Person Involved With Family

☐ Lack of Safe Parking Available ☐ Aggressive Animals ☐ Suspected Illegal Substances in Home ☐ Weapons in Home

Please describe: _____

_____

***Please note that the following criteria excludes youth for the service:**

1. The youth displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more intensive service beyond community-based interventions.
2. The youth has medical conditions or impairments that would prevent beneficial utilizations of services.
3. TM not needed to achieve identified treatment goal.
4. The youth's primary need is only for observation or for management during sport/physical activity, school, after-school activities, or recreation, or for parental respite.
5. The service needs identified in the treatment plan/care plan are being fully met by similar services.
6. The youth is placed in a residential treatment setting with no plans for return to the home setting.

Visit masspartnership.com for more information.

To complete referral:

Please fax referral form and attachments or place in Intake Supervisor's mailbox and call or email to inform of referral:

IHT and TM Intake Supervisor

Phone: 508-977-8129 Fax: 508-824-0111 Email: IHT.TMReferral@comcounseling.org

Thank you for placing this referral with CCBC.

Internal Use Only

Date received: _____

Assigned to: _____

Date Assigned: _____

Phone/Email Sent: _____ Initial: _____