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 Lauren Almeida, LICSW, Program Director for CSA at (508) 977-8185 / lalmeida@comcounseling.org or Kelley Michelangelo, LICSW, Senior Care Coordinator/Supervisor for CSA at (508) 977-8135 / kmichelangelo@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 a specific service provider. Those service providers include; 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): _____

INSURANCE: Insurances Accepted: *(Please check type of insurance and supply correct insurance number.)*
☐ MBHP ☐ BMC ☐ NHP ☐ Network Health MMIS (Insurance) 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.*)
_____
_____
_____

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: _____
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): _____