FAMILY SERVICE ASSOCIATION

THERAPEUTIC MENTORING
REFERRAL FORM

Please download and print this form. Complete it and bring, mail, or fax it to Family Service Association using the contact information listed at the bottom of the form.

Date of Referral: ________________________________ Child Car Safety Seat Needed? Yes No (Circle)

Child/Youth Name: ______________________________ The child/youth is: Male Female (Please circle one.)

Date of Birth:____________________________________ Social Security #: _____________________________

Full Address:____
Street City/Town State Zip Code

MMIS # / MassHealth #: ________________________________

Parent / Caregiver's Name: ______________________________ Relationship to child/youth: ______________

Home Phone:_____________________________ Cell Phone: ___________________________________

Primary language of child / family: ____

Primary Care Physician: ____

Is family / guardian aware and in agreement with referral? Yes No

Has family been informed about what the service offers? Yes No

Reason for Referral: ____
____
____
____

Please indicate if you would prefer a specific gender of the person providing mentoring services to the child / youth:
Male _________ Female ______________ No preference _______________

Primary Diagnosis: ______________________________________ DSM V/ICD10 Code: __________________
Secondary Diagnosis:_____________________________________ DSM V/ICD10 Code: __________________

Goal (s) of service to be provided: ____
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**Therapeutic Mentoring interventions are designed to address one or more goals on a youth's existing outpatient or In-home therapy treatment plan, or on an existing CSA Individual Care Plan.*

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Is the youth DCF- or DYS-involved? Yes No (circle one)

If yes, please list the name and contact information for the DCF/DYS caseworker(s) and briefly describe the reason for involvement:

____

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____

Is the youth currently being treated for an active medical diagnosis? Yes No (circle one)

If yes, please explain:

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Please include with this referral:
_______ Copy of release of information from referral source
_______ Copy of Care Plan or Treatment Plan recommending Therapeutic Mentoring
_______ Copy of CANS
_______ Copy of Risk Safety Plan (if completed)
_______ Copy of Comprehensive Assessment
_______ Copy of FSA Safety Assessment Scale (if this form is being completed by an FSA staff person)

Referred by: (check one)

_______ Intensive Care Coordinator _______ In-Home Therapist _______ Outpatient Therapist

Agency:_________________________________ Name of person referring: ______________________________

Phone: ____

Email Address: _______________________________________

If referred by ICC, has the therapeutic mentoring services been approved through the provider connect system?

_______Yes _______No _______Number of Units Approved

Please send to:

Family Service Association
Therapeutic Mentoring Program
21 Father DeValles Boulevard, Suite 104, Unit 13
Fall River, MA 02723
PHONE: 508-974-4560 FAX: (508) 679-0949 Email: TMReferral@frfsa.org

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