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WALKER
Teaching. Caring. Building Hope.

Walker Community Counseling
Referral – CBHI

☐ In-Home Therapy

☐ Therapeutic Mentoring

Date of Referral: ______________________

Eligibility Criteria for Therapeutic Mentoring:
- The youth is under 21 and has Mass Health with an ACO or MCO managing their behavioral health benefits.
- Youth meets medical necessity criteria.
- The HUB provider is making the referral and has obtained consent from the guardian to make the referral.
- A Comprehensive Assessment and CANS have been completed by the HUB for this youth – PLEASE ATTACH
- A Treatment Plan/Individualized Action Plan/Care Plan has been completed by the HUB for this youth and includes a specific goal for mentoring – PLEASE ATTACH
- If ICC is the hub, TM goal has been entered into Provider Connect.

Eligibility Criteria for In Home Therapy:
- The youth is under 21 and has Mass Health with an ACO or MCO managing their behavioral health benefits.
- Youth meets medical necessity criteria.
- Family is aware of referral and has consented to IHT service.

Child/Youth Information: Preferred Language: ☐English ☐Spanish ☐Other: ______________

Name: ______________________ D.O.B.: ______ Age: ________

Primary Insurance: ______________________ Subscriber/MMIS #: ______________________

Secondary Insurance: ______________________ Subscriber/MMIS #: ______________________

Ethnicity: ______________________ Gender: ______________________

Psychiatric Diagnosis*: DSM Code: ____________ Narrative: ______________________

DSM Code: ______________________ Narrative: ______________________

Who generated dx and when? ______________ PCP: ______________________

Including this information significantly assist in ability to gain authorization for service. Please include when possible.

Parent/Guardian Information: Preferred Language: ☐English ☐Spanish ☐Other: ______________

Name: ______________________ Ethnicity: ______________________

Relationship to Child: ______________________

Address: ______________________

Cell Phone: ______________________ Home Phone: ______________________

Best times to call/Scheduling Needs: ______________________

Legal Guardian (☐Same as above): ______________ Physical Custody (☐Same as above): ______________

Where does child currently live? ☐With Parent(s) ☐Foster Home ☐Group Home ☐Other ______________

If not with parent(s)/guardian(s) listed above, please give name, address and telephone number of current residence: ______________

Person Making Referral: Fax: ______________________

Name: ______________________ Organization/Agency: ______________________

Address: ______________________ Work Telephone: ______________________

Email: ______________________ Cell Phone: ______________________

Check Level of Care if Applicable: ☐N/A ☐CSA ☐IHT ☐Outpatient ☐ESP/MCI ☐CBAT ☐STARR ☐Hospital ☐Other: ______________

Brief description of your concerns and goals in referring child (please include any current safety concerns): *Please attach additional sheets if necessary*

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Past/Current Risk Factors: ☐ DV ☐Mental Illness ☐Substance Use Disorder ☐Abuse ☐Neglect ☐Medical Issues ☐Cultural Factors ☐Suicidal/Homicidal Ideation ☐Other: ______________________

Internal Use Only

Date of Referral			
Date Referral Accepted (Received Guardian Consent and Hub Documents Received if applicable)			
Outreach attempts to caregiver	Date	Outcome	Who Called
Date assigned			
Date services started			
First appointment offered			
First appointment accepted			