



Submit completed referrals and other required paperwork by email to MAhomebasedservices@c4p.org or by fax to 617-499-7684. For questions about referrals, email MAhomebasedservices@c4p.org or call 1-855-801-4622.

If the Youth is involved with Intensive Care Coordination, the ICC must submit the most recent safety plan, Individual Care Plan outlining goals for IHT, and agenda from the last CPT.

If DCF is the legal guardian of the Youth, the case worker must submit the guardianship mittimus and a release of information to facilitate communication between C4P and caregiver.

Referral Source

Form with fields for Date of referral, Name of referral source, Relationship to Youth, Agency, Phone #, and Email.

Youth Information

Form with fields for Name, Sex, Gender, Name used by Youth, Pronouns, Date of birth, Age, Race, Address, Ethnicity, Primary language, Language for services, and Phone, if 18 or older.

Section for Involvement with other services (select all which apply) including options like None/Unknown, Family-based Intensive Therapy (FIT), Intensive Care Coordination (ICC), etc.

Section for Involvement within the past 30 days with the following services (select all which apply) including options like Youth Mobile Crisis Intervention (YMCI) team, Intensive Outpatient (IOP), etc.

Text field: Is youth currently in an out-of-home placement with a plan to return to the home? If so, describe:

Form with fields for Insurance Plan and Insurance ID #.

Caregiver Information

Caregiver #1 name: _____ Relationship to Youth: _____ Address, if different than Youth: _____ _____ _____ Phone #: _____ Email: _____ Guardianship status: <input type="checkbox"/> Legal and physical <input type="checkbox"/> Legal only <input type="checkbox"/> Physical only <input type="checkbox"/> None <input type="checkbox"/> Unknown Primary language spoken: _____ Language to be used for services: _____	Caregiver #2 name: _____ Relationship to Youth: _____ Address, if different than Youth: _____ _____ _____ Phone #: _____ Email: _____ Guardianship status: <input type="checkbox"/> Legal and physical <input type="checkbox"/> Legal only <input type="checkbox"/> Physical only <input type="checkbox"/> None <input type="checkbox"/> Unknown Primary language spoken: _____ Language to be used for services: _____
If DCF holds legal guardianship, please provide the following information: DCF Case Worker name: _____ Area office: _____ Phone #: _____ Email: _____	

Referral Information

Please provide a brief description of the event/s that led to this referral being made: _____ _____ _____
Please provide other information about the Youth and family relevant to this referral (eg, Youth's diagnosis, other recent family stressors, and aims for treatment): _____ _____ _____
Please note any risk and safety factors experienced by the Youth and/or family (select all which apply): <input type="checkbox"/> None known or reported <input type="checkbox"/> Suicidal ideation, planning, or actions <input type="checkbox"/> Non-suicidal self-injury <input type="checkbox"/> Homicidal/aggressive ideation, planning, or actions <input type="checkbox"/> Running away <input type="checkbox"/> Substance misuse <input type="checkbox"/> Weapon/s in the home <input type="checkbox"/> Physical safety of family member/s at risk <input type="checkbox"/> Neighborhood safety <input type="checkbox"/> Significant medical conditions/illness <input type="checkbox"/> Other: _____