Italian Home for Children

# Centralized Intake Form for Outpatient & Community Services

This intake form is for our **Outpatient (CBHI); Partial Hospital Program (PHP); the Brighton Allston Mental Health Association (BAMHA) clinic; and our Out of School Time Therapeutic After School Programs or vacation camps.** Our vacation camp programs are active during February, March, April, and summer break.

For referral to our **Neurodevelopment Unit (NDU)**, please call the intake line at 857-762-2510.

To learn more about admission to the **Pallotta School**, contact the school directly at 617-525-3116 ext. 3030.

This referral form is **not** intended for emergencies. If the individual being referred is currently at risk of harm to themselves or others, or requires immediate intervention, **do not complete this form**. Please call **911**, go to the nearest emergency room, or contact the **988 Suicide & Crisis Lifeline** by calling or texting **988** for immediate support.

Required

## Program Choice

Choose the program for which you are making a referral.

1. Choose from these programs *

- ◯ Children's Behavioral Health Initiative (CBHI). These services are In-Home Therapy, In-Home Behavioral Services, and Therapeutic Mentoring.
- ◯ Partial Hospital Program (PHP)
- ◯ Brighton-Allston Mental Health Association (BAMHA) Clinic, is a diverse community mental health agency offering individual, couples, family, and group therapy, as well as psychopharmacology to clients ages 4-80+ years.
- ◯ Out of School Time programs (OOST)
- ◯ In-Home Therapy Services (IHT)
- ◯ In-Home Behavioral Services (IHBS)
- ◯ Therapeutic Mentoring Services (TM)
- ◯ Other

## Contact Information

For individual making the referral

2. Name (First, middle, last, suffix) *

3. Home address *

4. Relationship to client *

- ◯ Self
- ◯ Parent
- ◯ Guardian
- ◯ Grandparent
- ◯ Other

5. Email Address (if applicable)

6. Primary phone number *

7. Alternative phone number (if applicable)

8. Preferred contact method *

- ◯ Phone call
- ◯ Text message
- ◯ Email
- ◯ Other

9. Best time to contact *

- ◯ 9 a.m. to Noon
- ◯ Noon to 5 p.m.
- ◯ 5 p.m. to 8 p.m.

## Client Information

10. Client's full name (First, Last) *

11. Date of birth *

12. Client age *

13. Client's address (Street, Apt. #, City/Town, State, Zip) *

14. Parent/Guardian (Name & Relationship) *

15. Gender *

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Prefer not to say
- ◯ Other

16. Ethnicity/Race *

- ◯ Hispanic/Latino
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ Multiracial
- ◯ Prefer to self-describe: _____
- ◯ Prefer not to answer

17. Current living situation *

- ◯ At home (with parent(s), guardian(s), or family)
- ◯ At home (independently or with roommates)
- ◯ With relatives (extended family, kinship care)
- ◯ Living at home with spouse
- ◯ Living at home with partner
- ◯ Foster care (traditional, kinship, or therapeutic)
- ◯ Residential or group living program
- ◯ Transitional housing program
- ◯ Supportive housing
- ◯ Shelter or emergency housing
- ◯ Temporarily staying with friends or family
- ◯ Hospital or medical setting
- ◯ Juvenile justice or correctional setting
- ◯ Currently unhoused / without stable housing
- ◯ Other

18. Primary language spoken *

- ◯ English
- ◯ Spanish
- ◯ Haitian Creole
- ◯ Portuguese
- ◯ Cape Verdean Creole
- ◯ Vietnamese
- ◯ Mandarin Chinese
- ◯ Cantonese Chinese
- ◯ Arabic
- ◯ Other
- ◯ Prefer not to say

19. Are language interpretation services needed? *

- ◯ Yes
- ◯ No
- ◯ Not sure

20. Has the individual received services from Italian Home previously?

- ◯ Yes
- ◯ No
- ◯ Not sure

21. If answer is yes, please indicate date or dates of service

## Referral Source

**YOU MAY SKIP THIS SECTION IF YOU ARE THE PARENT MAKING THE REFERRAL**

22. Agency name

23. Agency location

24. Name of referring provider/individual

25. Title of referring provider/individual

26. Work phone

27. Email

28. Back-up/Supervisor name

29. Back-up/Supervisor phone number

30. What made you decide to choose this program at Italian Home?

## Section 5

Insurance & Medical Information

31. Insurance Provider *

32. If no insurance, please choose one of the below options: *

- ◯ Self-pay
- ◯ Other

33. Insurance Policy Number

34. Medicaid/Medicare ID (if applicable)

35. Primary Care Physician Name & Contact Info (phone and email)

36. Psychiatrist/Therapist Name & Contact Info (phone and email)

37. Current Diagnoses

## Section 6

Service Needs & Clinical Triage

38. Primary Concern *

39. Type of Program/Services Requested. Please include any accommodations required or preferred (e.g. hearing impaired, requesting female clinician, mobility assistance, etc.) *

## Section 7

Risk, Consent & Legal Acknowledgement

40. Risk Acknowledgement; HIPAA Acknowledgement & Privacy Concerns *

- [ ] "I acknowledge that I have read and understand the Privacy Policy." https://www.mass.gov/info-details/privacy-practices-hipaa-notices-and-acknowledgement-forms
- [ ] I acknowledge that this referral form is not for emergency situations and that no immediate safety concerns are present at the time of submission.

## Privacy

41. HIPAA Acknowledgement & Privacy Concerns *

- [ ] "I acknowledge that I have read and understand the Privacy Policy." https://www.mass.gov/info-details/privacy-practices-hipaa-notices-and-acknowledgement-forms