CBHI Referral Form 

Please fill out and email to CBHI@italianhome.org.

Service Requested:

Client Name:

DOB:

Age:

Gender:

Parent/Guardian (Name & Relationship):

Joint/Legal Custody (if parents are separated

Home Address:

Cell Phone:

Name of School Currently Attending:

Primary Language:

Fluent in English:

Legal Guardian Name (if different from above):

DCF Agency (if DCF has custody):

Address:

--------------------------------

Referral Source

Agency Name & Location:

Name:

Title:

Work Phone:

Cell Phone:

Email:

Back-up/Supervisor Name:

Phone:

How did you hear about Italian Home for Children?:

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

--------------------------------

Insurance Information

Managed Care Entity:

Plan Type:

Policy Number (12 digits):

--------------------------------

Other Providers

Current/Former IHC Client (yes/no):

If yes, please list program(s) and approximate dates):

State Agency Involvement?:

Worker's Name and Number if applicable:

Medical Necessity Criteria are met by one or more of the following:: is experiencing persistent behavioral problems, needs coaching, support, and educational services not provided by outpatient alone

Current DSM 5 Diagnosis (with ICD 10 code(s)::

DSM 5 (F code)::

Reason for referral / Goals for service:

--------------------------------

Family/Guardians

Is the family aware of and in agreement with being referred? What is the family hoping to get from the service?:

Who lives in the home (name/relationship to the child):