Intensive Behavioral Health Services (IBHS) Out of School Time Referral Form

Name of out of school time Program Referring:	
Name of Individual making Referral:	**Role:**
Email:	**Phone:**

child name:	**date of birth:**
medical assistance (ma) number, if known:	**other insurance, if known:**
address	**zip code**
parent/legal guardian name:	**relationship:**
phone:	**best time to call:**
email:	**primary language spoken in the home:**
Was the parent/legal guardian contacted about referral? Yes: ☐ No: ☐	
Is the parent willing to engage? Yes: ☐ No: ☐ **If NO, referral cannot be made without parent agreement. If YES, proceed with completing form**	

Describe concern/s leading to referral:
Describe interventions that have been tried: **Attach additional data (i.e. anecdotal notes, daily reports, etc.)**

Does the child have an IEP or 504? Yes: ☐ No: ☐ Unknown: ☐
Is there DHS involvement? Yes: ☐ No: ☐ Unknown: ☐
Is there Juvenile Justice involvement? Yes: ☐ No: ☐ Unknown: ☐

Name of IBHS provider Agency receiving referral:	**Date submitting referral:**
Provider Address:	
Provider Phone:	**Provider Email:**
Parent/Legal Guardian Signature	**Date Signed:**

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