Riverside Community Care

THE HELP YOU NEED CLOSE TO HOME

Community Service Program (CSP) Referral Form

Completed Referrals for the Community Support Program should be sent via secure email to **CSPReferral@Riversidecc.org** or **Faxed to 781-355-4277**. Please include a signed release and current medication list if available. All referrals reviewed within 48 business hours.

Referral Date: Enter Date Referral Sent to Riverside

Referral Source: Enter Referral Source Name

Referral Contact #: Enter Referral Phone & Email

CSP Authorization Information
Authorization #: Auth #.
Dates Authorized: Auth Date.
Units: Auth Units

Member Information:

Full Name: Member's Full Name	**DOB:** Date of Birth	**Gender:** Identified Gender
Address: Member's Full Home Address		
Telephone(s): Member's Phone Number	**MMIS**: MassHealth Number	
Insurance: MassHealth Standard is only eligible for CSP with one of the following Managed Care Entities ☐ MBHP ☐ Allways Health- My Care Family ☐ Tufts Public Plan (Medicaid only) ☐ Beacon/ BMC Healthnet (Medicaid) ☐ Beacon/Fallon or Beacon/Optum ☐ Commonwealth Care Alliance		
Legal Guardian Name and Telephone: ☐ N/A Member's Legal Guardian & Contact if applicable		
Client is aware of this referral: ☐ Yes ☐ No Comments: Comment	Client agrees to CSP services: ☐ Yes ☐ No Comments: Comment	

Diagnosis (Medical and Psychiatric):

Diagnosis	ID-10 Code (F-Code)	Comments
Psychiatric Diagnosis	Diagnosis Code	Comment
Psychiatric or Medical Diagnosis	Diagnosis Code	Comment

Providers: *Please include Medical, Psychiatric, Legal, Natural Supports, Other*

Agency	Service Provided	Contact Name	Contact Telephone(s)
Agency	Service Provided	Provider Name	Provider Phone # & Email
Agency	Service Provided	Provider Name	Provider Phone # & Email
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CSP Eligibility Criteria: (at least one of the following is required for medical necessity)

Member is at Risk of admission to a 24 hour behavioral health inpatient/diversionary service evidenced by:

☐ In the last 180 days: Discharge from a 24hr behavioral health inpatient or diversionary service.

☐ In the last 90 days: Multiple encounters with Emergency Service Providers or Emergency Departments.

☐ Documented barriers to accessing or consistently utilizing essential medical or behavioral health services.

Is there a history of violence?: ☐ Yes ☐ No If yes,

Violence towards	Most recent date	Information
Self	Date	Enter Information regarding member's most recent risk to themselves
Others	Date	Enter Information regarding member's most recent risk to others

Referral Information:

What are the documented barriers (homelessness, substance use, high ED utilization, etc.)?

Enter any documented Barriers for the member…

Hospitalizations in the past year. *Including medical, detox, psychiatric admissions, and ED visits*

Enter any known Hospitalizations; name, date, cause…

Need Areas or Barriers for CSP Care Planning:

☐ Insufficient income- **Comment:** Enter CSP goal to address this barrier

☐ Needs connection to outpatient providers (ie: Therapist, Prescriber)-**Comment:** Enter CSP goal to address this barrier

☐ Needs connection to health providers (ie: PCP)- **Comment:** Enter CSP goal to address this barrier

☐ Lacks social supports- **Comment:** Enter CSP goal to address this barrier

☐ Temporary assistance with transportation- **Comment:** Enter CSP goal to address this barrier

☐ Housing concerns or risk of homelessness- **Comment:** Enter CSP goal to address this barrier

☐ Lacks essential benefits- **Comment:** Enter CSP goal to address this barrier

☐ Legal Issues- **Comment:** Enter CSP goal to address this barrier

☐ Other: Enter CSP goal to address this barrier

Additional Comments: *ie: Member engagement suggestions, care goals, Discharge Plans*

Enter Additional Comments…