MST PROGRAM
REFERRAL FORM

Please send completed referrals to Kris Molinari, MST Supervisor, at KrisM@FourFeathersCounseling.com

IS MST THE "RIGHT FIT" FOR THE FAMILY?

Please ensure family understands and agrees with the following, prior to submitting this referral

____ The Child has Medicaid.

____ The child is age 12-17 and will not be turning 18 within the next 6 months.

____ The family is aware that MST therapists engage and work primarily with the caregivers to make necessary changes within their child's ecology and understands effective MST service delivery is not reliant on the youth's participation or engagement in sessions.

____ The family understands that their MST therapist will continue to work with the caregiver(s) ***even*** if youth refuses to engage in sessions.

____ Families understand that MST is an intensive program and that caregivers must be bought-in to meeting with their therapist multiple times per week, for 3 to 5 months. Session frequency and length of service is based on the family's individual needs but typically begins with 3 sessions per week.

____ The family and team agree to not recommend residential placement for up to 5 months during the course of MST services in order for the MST model to have the appropriate time and opportunity to make necessary and sustainable changes within the youth's ecology.

We cannot take referrals for youth who meet criteria below:

1. Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregiver(s).

2. Youth referred primarily due to concerns related to active suicidal, homicidal, or psychiatric behaviors.

3. Youth whose referral behaviors are predominantly a result of their individual mental health diagnoses (ex. PTSD, Bi-Polar Disorder, Anxiety Disorders) and not primarily the result of external factors in their ecology.

4. Youth who are on the Autism spectrum or with pervasive developmental delays and low cognitive functioning youth. Youth diagnosed with Asperger's Syndrome may qualify for MST services, upon further case review.

5. Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior).

Contact Information:

Name (person completing form) Agency:

Office Location/Address:

Cell Phone #: Date of Referral:

MST PROGRAM
REFERRAL FORM

Demographics of Child:

First Name: Middle: Last:

Medicaid ID#: Gender: ☐ M ☐ F

DOB: Age: Race: (optional)

Child's Current Residence:

Street: County:

State: Colorado Zip:

Legal Guardian(s): Name:

Address of Residence:

Primary Phone #: Secondary Phone #:

Guardian(s) Custody:

Married ☐ Yes

Sole ☐ Yes

Child Primary Language: Caregiver's Primary Language:

Does this family need an interpreters services ☐ Yes ☐ No

Primary Reason for Referral: (Please do not leave blank)

Which of the following behaviors does the child display: (check all that apply)

Note: Behaviors must be such that puts the youth at risk for out-of-home placement

	Verbal Aggression		Substance Use/Abuse
	Physical Aggression		Police Involvement/Criminal Behaviors
	Threatening/Posturing Behavior		Engagement with Negative Peers
	Significant Property Destruction		Running Away/Chronic Leaving Home Without Permission
	Truancy/Suspensions/Expulsion		Risk of failure at school due to behaviors