Bay State Community Services



Client Referral and Insurance Update Form (pg. 1 of 2)

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| **Community Services Agency (CSA)** | | **Home Based Services** | |
| Plymouth  430 Court Street  Suite 3  Plymouth, MA 02360  Tel: 508-830-3444 x 321  Fax: 508-746-3944 | Coastal  400 Washington Street  Suite 106  Braintree, MA 02184  Tel: 508-830-3444 x 321  Fax: 508-746-3944 | Plymouth  430 Court Street  Suite 3  Plymouth, MA 02360  Tel: 508-830-3444 x 321  Fax: 508-746-3944 | Coastal  400 Washington Street  Suite 106  Braintree, MA 02184  Tel: 508-830-3444 x 321  Fax: 508-746-3944 |
| Intensive Care Coordination (ICC): | | In-Home Therapy (IHT): | |
| Family Support & Training (FS&T): | | Therapeutic Mentoring (TM): | |

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| Referral Date: | Click here to enter a date. | Admission Date: | Click here to enter a date. |

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| Youth’s Name: | |  | | | | DOB: | | Click here to enter a date. | | | | | | | SSN: | | | |
| Gender: | Male | | Female | | Transgender (Preferred Pronoun?  He  She  They) | | | | | | | | | | | | | |
| Street Address: | | | | | | | | | City, State, Zip Code: | | | | | | | | | |
| Phone Number: | | | | | | | | | Is it ok to leave a message? | | | | | | Yes | | No | |
| Work Phone: | | | | | | | | | Is it ok to leave a message? | | | | | | Yes | | No | |
| Ethnicity: | Hispanic | | Non-Hispanic | | | | | | | | | | | | | | | |
| Race: | American Indian or Alaskan Native | | | | | | | | Asian | | | | | | Black or African | | | |
| Native Hawaiian or other Pacific Islander | | | | | | | |  | White | | | | | Other | | | |
| Parent/Legal Guardian Name(s): | | | | | | | | | | | Relationship: | | | | | | | |
| Phone Number: | | | | | | | | | Is it ok to leave a message? | | | | | | Yes | | No | |
| Has the youth been served by Bay State Community Services in the past? | | | | | | | | | | | | | | | Yes | | No | |
| Referred by: | | | | | | | | | Phone: | | | | | | | | | |
| If referred from 24-hour facility or other residential, date of discharge from the facility: Click here to enter a date. | | | | | | | | | | | | | | | | | | |
| What caused the person to seek services at this time? | | | | | | | | | | | | | | | | | | |
| Is the person in a dangerous situation? | | | | | | | | | | | | | | | Yes | | | No |
| Special Communication Needs? | | | | Sign Language Interpreter Needed | | | | | | | | TDD/TTY | | Assistive Listening Device(s) | | | | |
| Language Interpreter Services | | | | | | | | Other | | | None | | | |
| **Insurance Information (*To be completed by BSCS or referring agency*)** | | | | | | | | | | | | | | | | | | |
| PCC Name: | | | | | | | | | PCC Phone Number: | | | | | | | | | |
| Primary Insurance: | | | | | | | | | Subscriber: | | | | | | | | | |
| Policy#: | | | | | | | | | | | | | | | | | | |
| Auth#: | | | | | | | | | Auth Dates: Click here to enter a date.. | | | | | | Units: | | | |
| Secondary Insurance: | | | | | | | | | Subscriber: | | | | | | | | | |
| Policy#: | | | | | | | | | | | | | | | | | | |
| Is the Youth and/or family involved with any state agencies? (i.e., DMH, DCF, DPH, etc.) | | | | | | | | | | | | | | | * Yes | * No | | |
| Name: | | | | | | | Role: | | | | | | Phone: | | | | | |
| Name: | | | | | | | Role: | | | | | | Phone: | | | | | |
| **Primary Diagnosis:** | | | | | | | | | | | | | | | | | | |

# Bay State Community Services



**Client Referral and Insurance Update Form (pg. 2 of 2)**

**Youth Name:**       **DOB:** Click here to enter a date.

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| What are the identified strengths for the referred youth? What are the concerning behaviors present for the referred youth? How might the child’s caretaker(s) benefit from the services provided? What are the specific needs they may have? |

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| TM Assessed Needs Checklist: (TM) Goals  Basic/Beginning Social Skills  Advanced Social Skills  Dealing with Feelings  Alternatives to Anger/Anger Management Skills  Self-Management/Stress Management Skills  Problem Solving/Conflict Resolution Skills  Daily Living/Community Management Skills  Other Skills (Be as Specific as Possible):  Other Skills (Be as Specific as Possible): | |
| Are there any scheduling concerns? (examples: Cannot meet between 9 AM and 5 PM, Not able to meet on Monday’s) | |
| HUB services need to include the following in addition to this referral form: | |
| Copy of most recent CANS assessment  Copy of safety plan/risk assessment form  Copy of updated Treatment plan, including a goal (TM/Family Partner)  Assessed Needs Checklist (See above)  \*Services cannot start until these documents are received\* | |
| *OFFICE USE ONLY:* | |
| Entered into System  REVS Checked/Printed | Original to Billing  Copy to Staff |