Bay State Community Services
Client Referral and Insurance Update Form (pg. 1 of 2)

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):	

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

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		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:				

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

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?

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	☐ Original to Billing
☐ REVS Checked/Printed	☐ Copy to Staff