



Bay State Community Services, Inc.
Client Referral and Insurance Update Form

***Incomplete referral will delay services.**

<input type="checkbox"/> Plymouth Area Office 430 Court Street (Suite 3) Plymouth, MA 02360 Tel: 508-830-3444 x 321 Fax: 508-746-3944	<input type="checkbox"/> Coastal Area Office 400 Washington Street (Suite 106) Braintree, MA 02184 Tel: 508-830-3444 x 321 Fax: 508-746-3944
<input type="checkbox"/> Intensive Care Coordination (ICC):	<input type="checkbox"/> In-Home Family Therapy (IHT):
<input type="checkbox"/> Family Support & Training (FS&T):	<input type="checkbox"/> Therapeutic Mentoring (TM):

Referral Date: [Click here to enter a date.](#)

Youth's Name:		DOB:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Preferred Pronoun?	<input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They
Street Address:		City, State, Zip Code:	
Mailing Address (If different):			
Phone Number:		Is it ok to leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnicity:	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Race:	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African
	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other
Parent/Legal Guardian Name(s):		Relationship:	
Phone Number:		Is it ok to leave a message?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Custody Information:		Does family agree to services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the youth been served by Bay State Community Services in the past?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Referred by:	Title:	Agency:	Phone:
If referred from 24-hour facility or ESP, date of discharge/evaluation: Click here to enter a date.			
Is the person in a dangerous situation? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please explain.)			
Primary Language in the home:			
Special Communication Needs?	<input type="checkbox"/> Sign Language Interpreter needed	<input type="checkbox"/> TDD/TTY	<input type="checkbox"/> Assistive Listening Device(s)
	<input type="checkbox"/> Language Interpreter Services	<input type="checkbox"/> Other	<input type="checkbox"/> None
Primary Insurance:		Subscriber:	
Policy#:			
Secondary Insurance:		Subscriber:	
Policy#:			
Primary Diagnosis Needed:		Diagnosis Code:	
Primary Care Physician:		Role: PCP	Phone:
Is Youth and/or Family involved with other providers (i.e., DMH, DCF, DPH, OP, School, etc.)?		<input type="checkbox"/> Yes (If yes, please list below.)	<input type="checkbox"/> No
Name:	Role:	Phone:	
Name:	Role:	Phone:	
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<p>Reason for referral for youth and family? What are the specific needs they may have? How might the child's caretaker(s) benefit from services provided? What are the examples of behaviors and symptoms that make the youth meet this level of care?</p> <p>What are the referred youth's and families identified strengths and goals?</p> <p>Are there any scheduling concerns? (examples: Cannot meet between 9 AM and 5 PM, Not able to meet on Monday's) Any animals in home? If yes, please explain.</p> <table border="1"><thead><tr><th><u>TM Assessed Needs Checklist: (TM) Goals</u></th><th><u>FST Assessed Needs Checklist: (FST) Goals</u></th></tr></thead><tbody><tr><td><input type="checkbox"/> Basic/Beginning Social Skills</td><td><input type="checkbox"/> Psychoeducation around Youth's Diagnosis</td></tr><tr><td><input type="checkbox"/> Advanced Social Skills</td><td><input type="checkbox"/> Increase Parenting Skills</td></tr><tr><td><input type="checkbox"/> Dealing with Feelings</td><td><input type="checkbox"/> Increase Organizational Skills</td></tr><tr><td><input type="checkbox"/> Alternatives to Anger/Anger Management Skills</td><td><input type="checkbox"/> Implement Routine and Structure</td></tr><tr><td><input type="checkbox"/> Self-Management/Stress Management Skills</td><td><input type="checkbox"/> Access Community Resources</td></tr><tr><td><input type="checkbox"/> Problem Solving/Conflict Resolution Skills</td><td><input type="checkbox"/> Increase Educational Advocacy Skills</td></tr><tr><td><input type="checkbox"/> Daily Living/Community Management Skills</td><td><input type="checkbox"/> Develop Natural Supports</td></tr><tr><td><input type="checkbox"/> Other Skills (Be as Specific as Possible):</td><td><input type="checkbox"/> Other Skills (Be as Specific as Possible):</td></tr></tbody></table> <p>HUB services (TM & FS&T) need to include the following in addition to this referral form:</p> <table border="1"><tbody><tr><td><input type="checkbox"/> Copy of most recent Comprehensive Assessment/Intake Note</td></tr><tr><td><input type="checkbox"/> Copy of most recent CANS Assessment</td></tr><tr><td><input type="checkbox"/> Copy of Safety Plan/Risk Assessment Form</td></tr><tr><td><input type="checkbox"/> Copy of Updated Treatment Plan, including a goal for TM/FS&T</td></tr><tr><td><input type="checkbox"/> Assessed Needs Checklist (See above)</td></tr></tbody></table> <p>*Services cannot start until these documents are received*</p>				<u>TM Assessed Needs Checklist: (TM) Goals</u>	<u>FST Assessed Needs Checklist: (FST) Goals</u>	<input type="checkbox"/> Basic/Beginning Social Skills	<input type="checkbox"/> Psychoeducation around Youth's Diagnosis	<input type="checkbox"/> Advanced Social Skills	<input type="checkbox"/> Increase Parenting Skills	<input type="checkbox"/> Dealing with Feelings	<input type="checkbox"/> Increase Organizational Skills	<input type="checkbox"/> Alternatives to Anger/Anger Management Skills	<input type="checkbox"/> Implement Routine and Structure	<input type="checkbox"/> Self-Management/Stress Management Skills	<input type="checkbox"/> Access Community Resources	<input type="checkbox"/> Problem Solving/Conflict Resolution Skills	<input type="checkbox"/> Increase Educational Advocacy Skills	<input type="checkbox"/> Daily Living/Community Management Skills	<input type="checkbox"/> Develop Natural Supports	<input type="checkbox"/> Other Skills (Be as Specific as Possible):	<input type="checkbox"/> Other Skills (Be as Specific as Possible):	<input type="checkbox"/> Copy of most recent Comprehensive Assessment/Intake Note	<input type="checkbox"/> Copy of most recent CANS Assessment	<input type="checkbox"/> Copy of Safety Plan/Risk Assessment Form	<input type="checkbox"/> Copy of Updated Treatment Plan, including a goal for TM/FS&T	<input type="checkbox"/> Assessed Needs Checklist (See above)
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