

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

*Incomplete referral will delay services.

Plymouth Area Office 430 Court Street (Suite 3) Plymouth, MA 02360 Tel: 508-830-3444 x 321 Fax: 508-746-3944	Coastal Area Office 400 Washington Street (Suite 106) Braintree, MA 02184 Tel: 508-830-3444 x 321 Fax: 508-746-3944					
Intensive Care Coordination (ICC):	In-Home Family Therapy (IHT):					
Family Support & Training (FS&T):	Therapeutic Mentoring (TM):					
Referral Date: Click here to enter a date.						
Youth's Name: DOB:						
Gender: Male Female Transgender	Preferred Pronoun? He She They					
Street Address:	City, State, Zip Code:					
Mailing Address (If different):						
	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?					
Custody Information:	Does family agree to services? Yes No					
Has the youth been served by Bay State Community Services	in the past? Yes 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?						
Primary Language in the home:						
Special Communication Needs? Sign Language Interpreter TDD/TTY Assistive Listening Device needed						
Language Interpreter Se	ervices Other 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, DI	PH, OP, School, etc.)? Yes (If yes, please list below.) No					
Name:	Role: Phone:					
Name:	Role: Phone:					
Name:	Role: Phone:					
Name:	Role: Phone:					



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

*Incomplete referral will delay services.

Youth's Name:			DOB:		
	and family? What are the speci ices provided? What are the ex				
What are the referred youth's	and families identified strengt	hs and goals?			
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.					
TM Assessed Needs Checkl	st: (TM) Goals	FST Assessed N	leeds Checklist: (FS	T) Goals	
Basic/Beginning Social Advanced Social Skills Dealing with Feelings Alternatives to Anger/A Self-Management/Stre Problem Solving/Confli Daily Living/Communit Other Skills (Be as Spec	Anger Management Skills ss Management Skills ct Resolution Skills y Management Skills	Increase Paragrams Increase Or Implement Access Con Increase Econ Develop N	arenting Skills rganizational Skills Routine and Struction munity Resources ducational Advocacy atural Supports s (Be as Specific as	ure Skills	
HUB services (TM & FS&T) need to include the following in addition to this referral form:					
Copy of most recent Comprehensive Assessment/Intake Note Copy of most recent CANS Assessment Copy of Safety Plan/Risk Assessment Form Copy of Updated Treatment Plan, including a goal for TM/FS&T Assessed Needs Checklist (See above) *Services cannot start until these documents are received*					