



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:

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: <input style="width: 150px;" type="text" value="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: <i>PCP</i>	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:	
Name:	Role:	Phone:	
Name:	Role:	Phone:	

