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):*					
Phone Number:				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
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? ☐ Yes ☐ No (If yes, please explain.)					
Primary Language in the home:					
Special Communication Needs?	☐ Sign Language Interpreter needed		☐ TDD/TTY	☐ Assistive Listening Device(s)	
	☐ Language Interpreter Services		☐ 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, DPH, OP, School, etc.)? ☐ Yes (If yes, please list below.)					☐ No
Name:				Role:	Phone:
Name:				Role:	Phone:
Name:				Role:	Phone:
Name:				Role:	Phone:

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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?

What are the referred youth's and families identified strengths 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 Checklist: (TM) Goals	FST Assessed Needs Checklist: (FST) Goals
☐ Basic/Beginning Social Skills	☐ Psychoeducation around Youth's Diagnosis
☐ Advanced Social Skills	☐ Increase Parenting Skills
☐ Dealing with Feelings	☐ Increase Organizational Skills
☐ Alternatives to Anger/Anger Management Skills	☐ Implement Routine and Structure
☐ Self-Management/Stress Management Skills	☐ Access Community Resources
☐ Problem Solving/Conflict Resolution Skills	☐ Increase Educational Advocacy Skills
☐ Daily Living/Community Management Skills	☐ Develop Natural Supports
☐ Other Skills (Be as Specific as Possible):	☐ Other Skills (Be as Specific as Possible):

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