River Valley Counseling Center
Outpatient Clinics

Client #:_____

In-Home BEHAVIORAL Services Request Form

Date of Referral:_____ Language Spoken at Home:_____ Gender:_____

NAME of Child:_____ D.O.B.:_____

Address:_____City:_____ Zip:_____

Phone Numbers:_____

PARENT or GUARDIAN (Name and Rel'n):_____

Custody Status:_____

Referred By:_____ Agency:_____ Phone#:_____

Name of School Child Attends:_____

Insurance Information

MMIS Number:_____ Policy #:_____

MBHP:___MBHP/Be Healthy:___BMC/Fallon:____ Tufts/Network Health:___

Cigna:____ Optum:____ Aetna:____BCBS:_____HNE:____Other:_____

Reason for Referral:

Problem behavior(s) to be addressed (home/school/community). BE SPECIFIC:_____
_____
_____

Diagnoses:_____

****PLEASE FAX TO 413-594-1912 or scan and email to: lavallee_natalie@holyokehealth.com****

303 Beech Street, Holyoke, MA 01040 ● (413) 540-1100 ● Fax (413) 534-2601
249 Exchange Street, Chicopee, MA 01013 ● (413) 594-2141 ● Fax (413) 540-5801
152 Center Street, Chicopee, MA 01013 ● (413) 540-1214 ● Fax (413) 538-9126
120 Maple Street, Springfield, MA 01103 ● (413) 737-2437 ● Fax (413) 737-3521
Central Intake ● (413) 540-1234 ● Fax (413) 533-1016
rvcc-inc.org
A member of Valley Health Systems, Inc.

IHBS Coordination Only

Date Received:_____ Assigned Date:_____ Assigned To: _____

Date of 1st Contact:_____ 2nd Contact:_____ 3rd Contact:_____

Intake Date:_____ Discharge Date:_____

303 Beech Street, Holyoke, MA 01040 ● (413) 540-1100 ● Fax (413) 534-2601
249 Exchange Street, Chicopee, MA 01013 ● (413) 594-2141 ● Fax (413) 540-5801
152 Center Street, Chicopee, MA 01013 ● (413) 540-1214 ● Fax (413) 538-9126
120 Maple Street, Springfield, MA 01103 ● (413) 737-2437 ● Fax (413) 737-3521
Central Intake ● (413) 540-1234 ● Fax (413) 533-1016
rvcc-inc.org
A member of Valley Health Systems, Inc.