River Valley Counseling Center

CLIENT #:__________

In-Home THERAPY Service Request Form

Date of Referral:____________ Language Spoken at Home:________________ Gender:___________

NAME of Child:_______________________________________ D.O.B.:_____________________

Address:________________________________ City:______________________ Zip:__________

Phone number(s):____

PARENT or GUARDIAN (name and rel'n):____

Referred by:______________________________ Agency:___________ Phone#:_________________

Custody Status:____

Name of School Child Attends:____

Insurance Information

MMIS Number:_______________________________ Policy #:______________________________

MBHP:____MBHP-HNE:___ BMC/Fallon:____ Tufts/Network Health:____

Cigna:_____Optum: _____ Aetna:_____ BCBS:_____ HNE:_____ Other:_________________

Reason for Referral:

****Please remember: IHT is NOT Individual therapy that is provided on an outreach basis! This is intensive family therapy that is provided by a team of a Master's level clinician and Bachelor's level support worker. Family must be willing to meet AT LEAST once per week for AT LEAST two hours (often will be more than once per week).****

Behavioral issues/Symptoms that are being demonstrated in home/at school/in the community (Please include any actual or threatened harm to self/others):____

____

____

Is youth at risk of being removed from the home (e.g. Hospitalization? DCF placement? Residential?):____

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

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AREAS COVERED BY RVCC IHT TEAM: Springfield, Chicopee, Holyoke, S. Hadley, Agawam (including Feeding Hills), West Springfield, Easthampton, Ludlow, E. Longmeadow, Longmeadow, Hampden, Granby, Wilbraham.

IHT Coordination Only

Received:______________ **Assigned date:____________** **Assigned to:_______________________**

Date of 1st contact:_____________ **2nd contact:____________** **3rd contact:_____________________**

Intake Date:________________ **Discharge Date:___________________**