River Valley Counseling Center

CLIENT #: _____

In-Home THERAPY Service Request Form

Date of Referral: _____ Language Spoken by Client: _____ By Parent: _____

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

Gender (Legal): _____ How Identifies: _____ Pronouns: _____

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 BHCA: ☐

MMIS Number: _____ Policy #: _____

MBHP: ☐ Be Healthy: ☐ Wellsense/BMC/Fallon: ☐ Tufts/Healthy Together: ☐ Optum: ☐

Other insurance not listed: _____

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): (if you need more space, use next page)

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: rvccCBHIreferral@holyokehealth.com ****

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Behavior Issues/Symptoms Continued:

AREAS COVERED BY RVCC IHT TEAM: All Hampden County towns; the following Hampshire Co. towns: Northampton, Hadley, Easthampton, Belchertown, Amherst, So. Hadley, Hatfield, Westhampton, Southampton, Williamsburg, Granby, Pelham

IHT Coordination Only

Received: _____ Assigned date: _____ Assigned to: _____