River Valley Counseling Center
A Member of ServiceNet

SUBSTANCE USE PROGRAM

Outpatient Therapy Referral- SUD/SAS

Referral Source *choose one*: [ ] Self [ ] Beacon House [ ] Criminal Justice [ ] Comprehensive Care Center
[ ] Moltenbrey [ ] Orange recovery house [ ] Probation
[ ] Other *(community partners)*: ______________________________

Referral Contact Information: ______________________________

Type of Services *mark all that apply*: [ ] Outpatient/Medication [ ] Recovery Coach
[ ] Case management [ ] Group

Client Information:

Name: ______________________ DOB: ____________ Age: ________

Gender: ____________ Primary Language: [ ] English [ ] Spanish [ ] Other: ____________

Address: ______________________________

Phone: ____________________ Email: ____________________

For Minors and/or Guardianship

Parent/Guardian A: ____________________ Relationship: ____________

Address(es): ______________________________

Phone: ____________________ Email: ____________________

Parent/Guardian B: ____________________ Relationship: ____________

Address(es): ______________________________

Phone: ____________________ Email: ____________________

Health Insurance Information: *Therapy services are billed to the client's health insurance plan. The client (guarantor) is responsible for paying RVCC any out-of-pocket expenses that are required by the health insurance plan (ie: copays, co-insurance, and/or deductibles).*

- ★ Masshealth/Medicare __________ Social Security Number: ____________________
- ★ Primary Insurance: ____________ Policy Number *(required)*: ____________
  Policy Holder Name: ____________ Relationship to Client: ____________
  Policy Holder Address: ______________________________
- ★ Secondary Insurance (*if any, with policy#*) : ______________________________

Submit a copy of insurance and ID with referral form

Service Type Preference *mark all that apply*: [ ] In-Person [ ] Telehealth

In-person Clinic Preference *mark all that apply, if any*: [ ] Chicopee [ ] Easthampton [ ] Greenfield [ ] Holyoke
[ ] Northampton [ ] Springfield [ ] Westfield

Language *mark all that apply:* [ ] English [ ] Spanish [ ] Other: __________

Clinician *mark all that apply:* [ ] Woman [ ] Man [ ] LGBTQIA+ [ ] No preference

Other Preferences: ______________________________

Reasons for Referral:

Hospitalized in the last 30 days? [ ] No [ ] Yes- when and where? ____________________

Please email form to RVCC Central Registry at rvcc_ci@servicenet.org or fax to 413-534-2544