Youinc
An Affiliate of Seven Hills Foundation

Client Legal Name:	Client's Date of Birth:

Client's Contact Information:

Street 1:

Street 2:

City: **State:** **Zip Code:**

Phone number:

Above phone number is for: Client Caregiver **Permission to leave Voicemail:** Yes No

Client's email:

Primary language: **Is a translator needed?** Yes No

Are there any accessibility or communication needs? Yes No

If yes, please describe:

Client's Gender: Male Female Other **Is this different from client's gender on their insurance card?** Yes No
If Yes, what is client's gender on their insurance card?:

Legal Guardian Information:

Legal Guardian #1 N/A Client is above the age of 18	Legal Guardian #2 N/A Client is above the age of 18
Name:	**Name:**
Address:	**Address:**
Phone number:	**Phone number:**
Permission to leave Voicemail: Yes No	**Permission to leave Voicemail:** Yes No

DCF is legal guardian, please list Area Office:

Appointment Scheduling Information

If client is under 18, who should intake appointment be scheduled with?

Name: **Relationship to Client:**

Address:

Phone number:

Permission to leave Voicemail: Yes No

Email address :

Primary language: **Is a translator needed?** Yes No

Are there any accessibility or communication needs? Yes No

If yes, please describe:

(over)

Insurance Information **Required to process referral**

Primary Insurance Company Name:	Secondary Insurance Company:
Mass Health Card Number/Private Insurance Policy Number:	Mass Health Card Number/Private Insurance Policy Number:
Mass Health Sequence Number (MMIS)/Group Number:	Mass Health Sequence Number (MMIS)/Group Number:
Subscriber's Name:	Subscriber's Name:

Services Requested	Geographic Area for Services Requested
Clinic-based Counseling/Therapy	Gardner & Surrounding Community
In-home Counseling/Therapy	Milford & Surrounding Community
Care Coordination (ICC/Family Partner)	Southbridge & Surrounding Community
Resources and Supports	Worcester & Surrounding Community
Not Sure	
Other Services. Please Specify:	

Referral Narrative

Please describe the reason(s) for seeking services/making this referral.

Referral Source

Name:	Email Address:
Phone number:	Permission to leave Voicemail: Yes No
Company/Organization:	

Self | Internal YOU, Inc./Seven Hills | Primary Care Physician | DCF | CTTC/LINK KID

Parent/Foster Parent/Caregiver | ICBAT/CBAT | School | Other State Agency | External BH/MH Provider

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Please Email completed referral form and/or any questions to centralreferral@youinc.org
Referrals may be sent via fax to 508.849.5618