RISE BEHAVIORAL HEALTH SERVICES, LLC

150 Front Street, Suite 102
West Springfield MA 01089
referrals@risebhs.com | www.risebhs.com
Main: (413) 657-1917 | **Fax:** (413) 301-8205

REFERRAL FORM

DATE OF REFERRAL _____

REFERRAL PROCESS

1. If a **family member** is making a referral for IHT, FIT, IHBS, ICC, or ABA, Rise will complete the referral over the phone or accept the referral form and then follow up with the family. If a family calls about TM or FS&T, Rise will explain the process of identifying a hub provider.*
2. If a **provider** is making the referral, Rise will either:
   - **a.** Accept their completed referral form and follow up with the family, or
   - **b.** Complete the referral with Rise over the phone and follow up with the family.
3. In both cases, Rise will contact the family to review the referral and discuss the appropriate level of care, and will obtain consent if applicable. Once consent is received, the individual will be scheduled for an intake appointment or added to a waiting list for the appropriate Rise or other behavioral health service.
4. More detailed clinical and family information may be gathered during the intake process at Rise.

*** SERVICE ABBREVIATIONS**

TM Therapeutic Mentoring
IHT In-Home Therapy
IHBS In-Home Behavioral Services
FIT Family-based Intensive Treatment
FS&T Family Support & Training
ABA Applied Behavior Analysis
ICC Intensive Care Coordination

A SERVICE(S) REQUESTED

select one or more – see descriptions in section G

- ☐ Therapeutic Mentoring
- ☐ Family Support and Training
- ☐ In-Home Therapy
- ☐ Applied Behavior Analysis (ABA)
- ☐ In-Home Behavioral Services
- ☐ Intensive Care Coordination
- ☐ Family-based Intensive Treatment
- ☐ Other / Not Sure

B YOUTH / CLIENT INFORMATION

FULL LEGAL NAME

NICKNAME / CHOSEN NAME

DATE OF BIRTH

AGE

GENDER IDENTITY *(own words)*

PRONOUNS

RACE / ETHNICITY

GRADE IN SCHOOL

PRIMARY LANGUAGE

OTHER LANGUAGES SPOKEN

CURRENT ADDRESS

SCHOOL

YOUTH ON IEP / 504 PLAN? ☐ Yes ☐ No

C PARENT / CAREGIVER INFORMATION

PARENT / CAREGIVER NAME(S)

RELATIONSHIP TO YOUTH

PRIMARY LANGUAGE

OTHER LANGUAGES SPOKEN

WHO HAS THE RIGHT TO MAKE MEDICAL AND LEGAL DECISIONS FOR THE YOUTH?

CURRENT ADDRESS

EMAIL ADDRESS

PRIMARY PHONE

OKAY TO LEAVE MESSAGE? ☐ Yes ☐ No

SECONDARY PHONE

OKAY TO LEAVE MESSAGE? ☐ Yes ☐ No

D REFERRAL SOURCE *if not parent / caregiver*

REFERRAL SOURCE NAME

AGENCY

PHONE NUMBER

EMAIL ADDRESS

RELATIONSHIP TO YOUTH / CLIENT

FAMILY AWARE OF REFERRAL? ☐ Yes ☐ No

E INSURANCE & MEDICAL INFORMATION

PRIMARY INSURANCE

MEMBER / POLICY #

SUBSCRIBER NAME

SUBSCRIBER ID

PRIMARY CARE PHYSICIAN (PCP)

PCP PHONE

SECONDARY INSURANCE

SUBSCRIBER NAME

SUBSCRIBER ID

MEDICAL CONDITIONS / ALLERGIES

F REASON FOR REFERRAL

Provide a brief description of your goals, safety concerns, diagnosis, and/or other needs in making this referral:

RISK FACTORS *(e.g., DV, S/I, H/I, substance use, trauma)*

STRENGTHS

ANY OF THE FOLLOWING SERVICES IN THE LAST 30 DAYS?

- ☐ Hospital
- ☐ Community-Based Acute Treatment
- ☐ Partial Hospitalization Program
- ☐ Youth Community Crisis Stabilization
- ☐ Youth Mobile Crisis Intervention
- ☐ Other (please explain)

IF OTHER, PLEASE EXPLAIN

INVOLVEMENT WITH OTHER PROVIDERS

- ☐ DCF
- ☐ DMH
- ☐ DYS
- ☐ School

OTHER

G SERVICE DESCRIPTIONS

☐ Therapeutic Mentoring (TM)

Pairs a youth with an adult mentor to help the youth build and improve their social, communication, and life needs.

FREQUENCY Weekly sessions at home or in the community.
WHO BENEFITS Youth with moderate to severe behavioral health symptoms needing support in problem-solving, social skills, communication, or conflict resolution. The youth must also be receiving another behavioral health service (outpatient, IHT, IHBS, ICC, ABA, or FIT).

☐ Family Support and Training (FS&T)

Caregiver support and coaching provided by a Family Partner – a professional who also has lived experience caring for youth with special needs.

FREQUENCY 1–2 sessions per week at home or in the community.
WHO BENEFITS Caregivers wanting to become more effective advocates by understanding how to navigate systems and access community support. The youth must be receiving another behavioral health service (outpatient, IHT, IHBS, ABA, or ICC).

☐ In-Home Therapy (IHT)

Intensive family therapy provided by a team of two behavioral health staff to help youth with social, emotional, or behavioral challenges.

FREQUENCY 1–3 sessions per week at home or in the community.
WHO BENEFITS Families of youth with moderate to severe behavioral health symptoms wanting help to resolve conflicts, learn new ways to communicate, build helpful routines, and find community resources.

☐ In-Home Behavioral Services (IHBS)

Behaviorally based therapy provided by a two-person team that works directly with both the youth and the caregiver to develop a targeted behavior plan implemented at home.

FREQUENCY 1–3 sessions per week at home or in the community.
WHO BENEFITS Youth whose behaviors are significant enough to interfere with their functioning at home or in the community.

☐ Intensive Care Coordination (ICC)

Care planning service for youth with serious emotional and behavioral needs. Delivered by a care coordinator, often paired with a Family Partner (FS&T).

FREQUENCY Minimally 1 contact per week at home, in the community, or by phone.
WHO BENEFITS Youth with serious behavioral health symptoms, including co-occurring mental health and Autism Spectrum Disorder, who need coordination across multiple services. The care coordinator facilitates a team-based process to create one unified plan.

☐ Family-based Intensive Treatment (FIT)

Combines intensive family therapy, care coordination, and caregiver support for youth with serious behavioral and emotional needs. Delivered by a team of two behavioral health staff and a Family Partner.

FREQUENCY 3–5 sessions per week at home or in the community.
WHO BENEFITS Youth with significant behavioral health symptoms, including co-occurring Autism Spectrum Disorder, whose needs have required acute or urgent services in the last 30 days. The focus is to stabilize, strengthen family supports, and transition to outpatient or IHT in 4–6 months.

☐ Applied Behavior Analysis (ABA)

Evidence-based therapeutic approach that applies principles of learning and behavior to improve socially significant behaviors. A Board Certified Behavior Analyst (BCBA) develops and oversees individualized treatment plans, while Registered Behavior Technicians (RBTs) or Behavior Technicians deliver direct therapy.

FREQUENCY Session length and timing will be determined after a BCBA completes a thorough and comprehensive Initial Assessment, delivered at home, in the community, or in a clinical setting.
WHO BENEFITS Youth diagnosed with Autism Spectrum Disorder or Down Syndrome who need structured, individualized intervention to develop communication, social, adaptive, and daily living skills, and/or to reduce challenging behaviors. ABA may be provided alongside other services such as IHT, ICC, or FIT.

H REQUIRED ATTACHMENTS

FOR FAMILY SUPPORT & TRAINING, AND THERAPEUTIC MENTORING

- ☐ A Comprehensive Assessment and CANS completed for the youth – **PLEASE ATTACH**
- ☐ A Treatment Plan / Individualized Action Plan / Care Plan for the youth that includes a specific goal with objective outcome measures pertaining to the development of parent/caregiver capacity to parent the youth in the home or community – **PLEASE ATTACH**

FOR APPLIED BEHAVIOR ANALYSIS (ABA)

- ☐ Diagnostic evaluation confirming ASD or qualifying diagnosis – **PLEASE ATTACH**
- ☐ Physical completed within the last 12 months – **PLEASE ATTACH**

SUBMISSION & AUTHORIZATION

REFERRING PARTY SIGNATURE	PRINTED NAME	DATE