Quincy Family Resource Center
A program of Bay State Community Services, Inc.
1120 Hancock St. First Floor
Quincy, MA 02169
Phone: 617-481-7227 Fax: 617-845-9250

Referral for Services

Date of Referral:		**Date Referral Received:**			
Referred Participant's Name:		**Date of Birth:**		**Age**	
Referred Participant's Address/Street:				**Apt/Unit #:**	
City/Town:		**State:**		**Zip Code:**	
Phone #:		**Alternate Phone:**		**Email:**	
Education/School Placement::		**Employer:**			
Parent(s)/Guardian(s) Information: *Only required if referred participant is a minor under the age of 18 years*					
Name:		**DOB:**		**Phone #:**	
Address:(if different from referred participant):					
Relationship to Referred Participant:		**Email:**			
Name:		**DOB:**		**Phone #:**	
Address: (if different from referred participant):				**DOB:**	
Relationship to Referred Participant:		**Email:**			
Who does participant currently live with?					
Primary language spoken in the home:			**Religion:**		

Race/Ethnicity of Referred Participant / Family

(Check all that apply)

- ☐ No, Not Hispanic
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican ☐ Yes, Cuban
- ☐ Yes, Another Hispanic, Latino, or Spanish Origin
- ☐ White
- ☐ Black / African American
- ☐ Asian ☐ Indian ☐ Japanese ☐ Native Hawaiian ☐ Chinese ☐ Korean
- ☐ Guamanian or Chamorro ☐ Filipino
- ☐ Vietnamese ☐ Samoan
- American Indian or Alaska Native- *Write in name of enrolled or principal tribe.*
- Other Race/Ethnicity

Insurance Information

Primary Insurance:

Policy #:

Subscriber:

SS#:

PCP Name:

& Phone #:

MCE Contact:

Phone #:

Secondary Insurance:

Policy #:

Subscriber:

SS #:

Managed by:

Has the participant/family utilized the QFRC before? ☐ **Yes** ☐ **No**

Referred Participant's Name:

Date of Birth: **Age:**

Quincy Family Resource Center
A program of Bay State Community Services, Inc.
Referral for Services Form pg. 2
Phone: 617-481-7227 ~ Fax: 617-845-9250

Referral Source Information

☐ Parent/Guardian ☐ Self-Referral
☐ Police ☐ Court ☐ School
☐ Community Agency
☐ State Agency
☐ Other

Name:
Agency :
Phone:
Fax:
Email:

CRA (Child Requiring Assistance) Related Cases

Is this a CRA-Related Referral? ☐ **Yes** ☐ **No**

Reason(s) for Referral if "Yes" (Check all that apply)**:**

☐ Runaway
☐ Stubborn Child / Child not following rules
☐ Habitual School Offender
☐ Habitual Truant ☐ School Avoidance
☐ Sexually Exploited Child
☐ Juvenile Diversion** (LEADS Program)

*****JUVENILE DIVERSION REFERRALS PLEASE ATTACH RELEASE OF INFORMATION AND POLICE REPORT*****

Reason(s) for Referral for non CRA-Related cases:

(Check all that apply)

☐ QFRC Sponsored Groups / Events / Activities
☐ Basic Needs Resources
☐ Housing Resources / Assistance
☐ School Support Services
☐ Behavioral Health Resources
☐ Parent Education Groups
☐ Other (describe)

Presenting Needs of the Participant / Family

Collateral Agencies / Providers

Is the participant referred and/or family currently involved with any community and/or state agencies (i.e., Social Service Agencies, DCF, DMH, DDS, DPH, etc.)?

☐ **Yes** ☐ **No**

If "Yes" please list names and contact information

Current Legal Involvement

(If applicable please describe)

To be completed by QFRC Staff:

Date of Initial Phone Contact:

Contacted by:

_____

Date of scheduled first visit:

Appointment is with:

To be completed by QFRC Staff:

Date of Safety/Risk Management Plan:
(Signed if indicated)

Safety Plan completed with: