



Volunteers of America of Massachusetts (VOAMASS) Residential Rehabilitation Services (RRS) Referral Form

Date of referral: _____

I am making a referral to:

Men’s Hello House - Mass Ave (co-occurring enhanced RRS for mental health and SUD)
Men’s Hello House - Burt Street (co-occurring enhanced RRS for mental health and SUD)

Women’s Hello House (RRS for SUD)
Women’s Shiloh House (co-occurring enhanced RRS for mental health and SUD)

CLIENT INFORMATION

Name: _____

Phone number and email address: _____

Date of birth: _____

Social security number: _____

Preferred pronouns: _____

Are you Hispanic or Latinx? Yes No Prefer not to answer

What is your race? Alaska Native American Indian Asian

Black or African-American Native Hawaiian or Other Pacific Islander

White Unknown Other

Health insurance plan name and member ID number: _____

Emergency contact (name, relationship, and phone number):

REFERRING STAFF MEMBER INFORMATION

Staff member name and agency: _____

Direct phone number and email address: _____

HEALTH INFORMATION

Mental Health and Substance Use Disorder Information

Please list all mental health and/or substance use disorder diagnoses below.

1. _____ Diagnosed by: _____ Year: _____

2. _____ Diagnosed by: _____ Year: _____

3. _____ Diagnosed by: _____ Year: _____

4. _____ Diagnosed by: _____ Year: _____

5. _____ Diagnosed by: _____ Year: _____

6. _____ Diagnosed by: _____ Year: _____

Do you take medication for any of these diagnoses? Yes No

If yes, please list medications taken to treat these diagnoses:

Mental Health Providers

Do you currently have a mental health therapist? Yes No

If yes, provider name and contact information:

When was the last time you were seen by any type of mental health provider (e.g., therapist, psychiatrist, etc.)? _____

Do you currently have a psychiatric prescriber (e.g., psychiatrist, nurse practitioner)?

Yes

No

If yes, provider name and contact information:

Medical Information

Please describe all medical conditions below.

Do you take medication for any of these conditions? Yes No



If yes, please list medications below to treat these conditions:

Please list all current medical providers connected to your care:

Name: _____
Specialty: _____ Organization/Practice Name: _____

ELIGIBILITY INFORMATION

Have you experienced any of the following?

An inpatient psychiatric stay within the last 90 days? Yes No

If yes, dates of stay: _____ Name of facility: _____

Reason for admission: _____

Plan at time of discharge: _____

Two or more emergency department visits, or behavioral health emergency services program visits, within the last 90 days? Yes No

If yes please share information on at least two of the visits:

1. Date of admission: _____ Name of hospital: _____

Reason for admission: _____

Plan at time of discharge: _____

2. Date of admission: _____ Name of hospital: _____

Reason for admission: _____

Plan at time of discharge: _____



Been to multiple Clinical Stabilization Services (CSS), Transitional Support Services (TSS), or residential recovery programs within the past 90 days?

Yes

No

If yes, please describe, and indicate which services you have attempted to engage with in the past 90 days:

OTHER INFORMATION

Some of our programs have bunk beds. **Do you have any issues that would prevent you from accessing and sleeping in a top bunk?**

Yes

No

Do you currently have any pending legal issues?

If yes, where and what charges:

Yes

No

Do you currently receive any income?

If yes, please describe:

Yes

No

Please describe what you would like to get out of your stay with us and how you think we can best support you during this time:

Please attach a biopsychosocial assessment, a full medication list, and a recent TB screen to this referral and fax to: 617-506-7508 or email to: residentialtreatment@voamass.org