

# Steppingstone Incorporated

## Recovery Coach - Referral Form

Participants must possess a substance use or co-occurring disorder

A Recovery Coach promotes recovery by helping remove barriers and obstacles to recovery and serves as a personal guide and mentor for people seeking or already in recovery.

Referral Source (Self-referral if not agency): \_\_\_\_\_

Have you received Recovery Coaching Services elsewhere within the last 30 days?  Yes  No

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment: \_\_\_\_\_

Email Address: \_\_\_\_\_

Drug of Choice: \_\_\_\_\_ MH Diagnosis: \_\_\_\_\_

How did hear about us? \_\_\_\_\_

**Referral can be faxed or emailed to: (508) 675-3682 – mbryant@steppingstoneinc.org**

### Steppingstone Inc. Staff will complete the following section.

#### Insurance:

MassHealth  Other  Uninsured

Member ID: \_\_\_\_\_

#### If MassHealth:

Beacon  BMC HealthNet  Fallon Health

Neighborhood Health  MBHP  Tufts  Other

#### If Beacon, MBHP, Tufts, BMC HealthNet, Fallon or Neighborhood Health:

Secondary ID: \_\_\_\_\_ Group #: \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Steppingstone Inc. Staff Who Completed

Will be billing:  Insurance  BSAS

Insurance Authorization #: \_\_\_\_\_ Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ --- \_\_\_\_/\_\_\_\_/\_\_\_\_

Recovery Coach Assigned: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_