Families in Transition (Project FIT)
Behavioral Health Network
110 Maple Street Springfield, MA 01105
Phone: 413-304-2904 / Fax: 413-737-3000

Referred by (Name & Phone Number): _____

☐ **Wayfinders**	☐ **ED:**
☐ **Home City Housing**	☐ **Crisis**
☐ **Springfield Housing**	☐ **Other:**

Person Served Information:

Name:		**DOB**		**Social Security Number**	
Address:					
Primary Phone:			**Other Phone:**		
Primary Language:			**Race/Ethnicity:**		
Marital Status:	☐ Married ☐ Single ☐ Unknown				
Legal guardian?	☐ Yes ☐ No If yes, who?				

Reason for referral to FIT:

1. **Describe the Housing problem?**
2. **How many kids in the family?**
3. **What is the Behavioral health need? Who has the behavioral health need?**

Members in the household?		
Name:	**DOB & SSN:**	**Relationship to Head of Household:**
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Current/History of Suicidal or Homicidal Ideation? ☐ Yes ☐ No If yes, please explain:
Safety Concerns: ☐ Yes ☐ No If yes, please explain:
Other Information that might be helpful including barriers to achieving goals independently:

Agency Involvement: (list current providers)

Type of Service:	Provider Name:	Agency / Clinic:	Phone:
Primary Care Physician:			
Outpatient therapist/Psychiatrist:			
State Agency:			
Housing:			
Probation:			
Other:			

FOR SUPERVISORS USE ONLY:

Meet Criteria?
☐ Yes
Assigned to: Appointment date:
☐ No
Why?