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| **Person Completing Form:** | |
| **Phone:** | **Date:** |

**SERVICE REQUESTED**

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| **Children’s Targeted Case Management**  Behavioral Health  Developmental Disabilities  Chronic Medical Conditions **Adult Targeted Case Management**  Adult’s – HIV  Services for Homeless Individuals  **Community Integration Services**  C.I. Case Management  Skills Development  DLSS  **Outpatient Therapy**  Individual Counseling  Couple’s Counseling **Specialized Groups**  WRAP Recovery Workbook  TREM  DBT  **Behavioral Health Home Services**  Care Coordination |

**CLIENT BASIC INFORMATION**

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| **Client Name:** | **D.O.B.:**  **S.S.N.:** | | | **Gender:**  Male  Female |
| **Address:** | | | | |
| **Phone:** | | **Primary Language:** | | |
| **Client is a class member of:**  AMHI Consent Decree  Pineland Consent Decree  French Lawsuit  None Specialized Groups: Group Name:\_\_\_\_\_\_\_\_\_\_\_\_ Group Name:\_\_\_\_\_\_\_\_\_\_\_ Group Name:\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Is the client his/her own guardian?**  Yes  No (If no, please send proof of guardianship unless the client is a minor child and the guardian is a parent) | | | | |
| **MaineCare**:  Yes  No  If no, funding source:  If private insurance, please provide copy of card. | | | **MaineCare #:** | |
| **Diagnoses (must be within the last 12 months)** | | | **Prescriber and credential:** | |

**Please attach a copy of the client’s records**

**Please note, no “Unspecified” diagnoses can be accepted.**

***Thank you for your referral!***

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| **OFFICE USE ONLY**  Received By: Date: |