Maine Children's Home

Phone: 207-873-4253
Fax: 207-877-9435

REQUEST FOR SERVICES

Date of Referral:	Client Date of Birth:	Gender: ☐ M ☐ F ☐ X
First Name:	Middle Initial:	Last Name:
Address:	City:	State: / Zip Code:
Home #:	Work #:	Cell #: / Okay to text: ☐yes ☐ no
Contact Person:	Email (optional):	
Service(s) Requested: ☐ Counseling ☐ Targeted Case Management		
Reason for Referral:		

If Minor:

Does the child live with parent(s)? ☐ yes ☐ no	Do both parents agree to services? ☐ yes ☐ no	Is there a custody / guardianship agreement in place? ☐ yes ☐ no	If yes, MCH's requires a copy of the legal agreement at intake. 2nd appointment will **not** be scheduled until a copy is on file.
Parent or Guardian 1 Name:		Relationship to child:	
Address:	City:	State:	Zip Code:
Home #:	Work #:	Cell #:	Okay to text: ☐Yes ☐ No
Parent or Guardian 2 Name:		Relationship to child:	
Address:	City:	State:	Zip Code:
Home #:	Work #:	Cell #:	Okay to text: ☐ Yes ☐ No

Insurance Information (All sources of coverage must be listed)
***Please note Targeted Case Management requires MaineCare for insurance.**

MaineCare Number:		
Medicare: ☐ Yes ☐ No	Medicare Member Number:	
Private Insurance: ☐ Yes ☐ No	Insurance Company:	Certificate/Group #:
Subscriber Name:	DOB:	Primary Insurance: Secondary Insurance (if applicable):
Name of person making the referral:	How did they hear about MCH:	

For Office Use Only:

TCM referral entered into Acentra: ☐ Yes ☐ No Date entered:	
Assigned to:	Date:
Registered in TS: ☐ Yes ☐ No On data sheet: ☐ Yes ☐ No Registered in Acentra ☐ Yes ☐ No Verified insurance: ☐ Yes ☐ No	

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For TCM referral only:

Does the child have a mental health diagnosis? ☐ Yes ☐ No	Within the last 12 months? ☐ Yes ☐ No
Person/agency diagnosed by:	Diagnosis of:
Current mental health/behavioral health services the child is receiving:	