

Phone: 207-873-4253

Fax: 207-877-9435

Email: Connect@MaineChildrensHome.org

REQUEST FOR SERVICES

Date of Referral:	lient Date of	Birth:	Gender: M F X				
First Name:		Middle Initial:		Last Nan	Last Name:		
Address:			City:	Stat	e:	Zip Code:	
Home #:	Work #:		Cell #:		Okay to te	ext: □yes □ no	
Contact Person:			Email (optional):				
Service(s) Requested:		□ Targeted	Case Manage	ment			
Reason for Referral:							
If Minor:							
Does the child live with	Do both parents agree		a custody /		•	res a copy of	

	ves □	guardianship agreement in place? □ yes □ no			the legal agreement at intake. 2 nd appointment will not be scheduled until a copy is on file.		
Parent or Guardian 1 Name:			Relationship to child:				
0	City:			State		Zip Code:	
Work #:		C	Cell #:		Oka	ay to text: □Yes □	∃ No
Name:	R	Relatior	nship to child:				
0	City:			State		Zip Code:	
Work #:			Cell #:		Oka	ay to text: \Box Yes	🗆 No
	to services? volume: Vame: Vork #: Vame: Vame: Vame: Vame: Vame:	Name: City: Work #: Name: City:	to services? yes guardia place? Name: City: Work #: Relation City:	to services? yes guardianship agreement place? yes no Name: City: Work #: Cell #: Name: City: Cell #: Cell #	to services? yes guardianship agreement in place? yes no Name: City: Vork #: Cell #: Name: City: State State Cell #: State St	to services? yes guardianship agreement in place? yes no the lega appoint until a co state: Vame: Cell #: Cel	to services? yes guardianship agreement in place? the legal agreement at intal appointment will not be schuntil a copy is on file. Name: Relationship to child: Zip Code: Work #: Cell #: Okay to text: □Yes □ Name: Relationship to child: Zip Code: Name: Cell #: Okay to text: □Yes □ Name: City: State: Zip Code:

Insurance Information (All sources of coverage must be listed)

*Please note Targeted Case Management requires MaineCare for insurance.

MaineCare Number:					
Medicare: 🗆 Yes 🗆 No	Medica	are Member N	lumber:		
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						



For TCM referral only:

Does the child have a mental health diagno	osis? 🗆 Yes 🛛 No	Within the last 12 months? Yes No			
Person/agency diagnosed by:	Diagno	sis of:			
Current mental health/behavioral health services the child is receiving:					