Phone: 207-873-4253 Fax: 207-877-9435 Email: Connect@MaineChildrensHome.org

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	

For TCM referral only:

<table>
<tr><td colspan="2">Does the child have a mental health diagnosis? ☐ Yes ☐ No</td><td>Within the last 12 months? ☐ Yes ☐ No</td></tr>
<tr><td>Person/agency diagnosed by:</td><td colspan="2">Diagnosis of:</td></tr>
<tr><td colspan="3">Current mental health/behavioral health services the child is receiving:</td></tr>
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