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

**SERVICE REQUESTED**

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| **Community Integration Services** [ ]  C.I. Case Management **Behavioral Health Home Services** ☐ Care Coordination**Outpatient Therapy** [ ]  Individual Counseling [ ]  Couple’s Counseling |

**CLIENT BASIC INFORMATION**

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| **Client Name:**  | **D.O.B.:** **S.S.N.:**  | **Gender:**[ ]  Male [ ]  Female |
| **Address:**  |
| **Phone:**  | **Primary Language:** English |
| **Client is a class member of:**[ ]  AMHI Consent Decree [ ]  Pineland Consent Decree [ ]  French Lawsuit [ ]  None  |
| **Is the client his/her own guardian?** [ ]  Yes [ ]  No (If no, please send proof of guardianship)  |
| **MaineCare**: [ ]  Yes [ ]  NoIf 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: |