DHHS Children's Referral
Day Habilitation Services

Date Received in District Office _____

(*Required) Referral Packet must include: ☐ **Diagnostic Evaluation** ☐ **Guardians signature**

Individual Requesting Service: Relation to Child:

Contact Information:

Name: (Person completing form) Agency:

Office Location/Address: Phone Number: Ext:

Signature of person completing form: Date:

Demographics of Child: *Child's Name (spelled as it appears on the MaineCare Card)

First: MI: Last:

Gender ☐ Male ☐ Female

DOB: SSN: Maine Care #: Race: (optional)

Child's Current Residence (Legal Address where child will receive services)

Street:

Town: ME Zip: Phone:

Legal Guardian(s) Name & mailing address:

Phone#: Cell

Shared Custody Name & mailing address

Phone#: Cell

Guardian(s) Custody

Married ☐ yes
Sole ☐ yes
Shared ☐ yes name/address under Shared Custody
DHHS ☐ yes
Own ☐ yes

Primary Diagnosis

☐ MR/Autism Axis 2:
☐ MH Axis 1:
☐ EI/DD

Child's Primary Language :

Caregiver's Primary Language:

Does the family utilize interpreter services: ☐ yes ☐ no

Name of the interpreter & contact information:

Mail/Fax Form to:
Region 1 Districts 1 & 2 DHHS/CBHS 161 Marginal Way, Portland, ME 04101 Fax: 822-2358
Region 2 Districts 3 & 4 & 5 DHHS/CBHS 200 Main St Lewiston, Me 04240 Fax: 795-4445
Region 3 Districts 6 & 7 & 8 DHHS/CBHS 176 Hogan Rd, Bangor, ME 04401 Mail Referrals

Description of Identified Need: (please attached additional sheets as needed)

☐ Is Child aggressive? Explain:_____

Please review the following services and check off those, which are currently provided or have been in the past.

Service	Current	Past	Provider	Frequency	Duration	Active involvement Yes or No	Beneficial Yes or No
Psychiatry/Med Mgt.							
Outpatient Tx.							
Hospital							
Mobile Crisis							
Family Therapy							
Home Based Services							
Partial Hospital Program/IOP							
Crisis Unit							
Residential Tx.							
School/Preschool							
Other							

Release of Information

As the parent/guardian of this child (or self, when own guardian),

☐ **Yes (I agree)** ☐ **No (I disagree)** to the release of the information contained within this application, but only to a receiving provider agency as part of the treatment planning process.

_____

My signature below indicates my approval of the above statement

Parent/guardian: _____ Date: _____

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