



**DHHS Children's Referral  
Targeted Case Management**

**Referral Date:** \_\_\_\_\_ **\*(Required)**

Individual Requesting Service:

Relation to Child:

<b>Contact Information:</b> <input type="checkbox"/> High Fidelity Referral	
Name:	Agency:
Office Address:	
Phone Number:	Ext:

<b>Demographics of Child:</b> (Child's name spelled as it appears on the MaineCare Card)				
First:	MI:	Last:	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
DOB:	SSN:	Maine Care #:	Race:	(optional)

<b>Child's Current Residence</b> (Legal Address where child will receive services)				
Street:				
Town:	ME	Zip:	Phone:	Cell

<b>Legal Guardian(s)</b> Name & mailing address:	<b>Guardian(s) Custody</b>
Phone#:	Cell
	Married <input type="checkbox"/> yes Sole <input type="checkbox"/> yes Shared <input type="checkbox"/> yes fill in name/address below DHHS <input type="checkbox"/> yes Own <input type="checkbox"/> yes

<b>Shared Custody</b> Name & mailing address:
Phone#:
Cell

<b>Primary Diagnosis</b> <input type="checkbox"/> MR/AUTISM: <input type="checkbox"/> MH: <input type="checkbox"/> EI/DD
Axis I:
Axis II:

<b>Child's Primary Language:</b>	Caregivers Primary Language:
Does this family utilize interpreter services? <input type="checkbox"/> yes <input type="checkbox"/> no	
Name of Interpreter & Contact information:	