



Child and Family Services

*An Office of the
Department of Health and Human Services*

Referral

MaineCare Section 28,
Rehabilitative and Community Support Services
for Children with Cognitive Impairments
and Functional Limitations (RCS)

Date Received in District Office: _____

Referral Packet must include:

- Parent/Guardian's Signature**
- Diagnostic Evaluation**
- Physician's Letter of Eligibility (Birth – 5)**
- Functional Assessment Score Summary Sheet**

Individual Requesting Service: _____ Relation to Child: _____

<u>Contact Information</u>	
Name: _____	Agency: _____
(Person completing form) Are you the case manager: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Office Location/Address: _____	
Phone Number: _____	Ext: _____
Signature of person completing form: _____ Date: _____	

<u>Information about Child:</u> Child's Name (spelled as it appears on the MaineCare Card)		
First: _____	MI: _____	Last: _____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: (optional) _____	
DOB: _____	SSN: _____	Maine Care #: _____
<u>Legal address where child will receive services</u>		
Street: _____		
Town: _____	State _____	Zip: _____ Phone: _____

<u>Child's Primary Language :</u>
Caregiver's Primary Language: _____
Does the family utilize interpreter services: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the interpreter & contact information: _____



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<p><u>Legal Guardian(s)</u> Name & mailing address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone #: _____ Cell: _____</p> <p><u>Shared Custody</u> Name & mailing address</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Phone #: _____ Cell: _____</p>	<p><u>Guardian(s) Custody</u></p> <p>Married <input type="checkbox"/> Yes</p> <p>Sole <input type="checkbox"/> Yes</p> <p>Shared <input type="checkbox"/> Yes</p> <p>Name/Address under Shared Custody</p> <p>DHHS <input type="checkbox"/> Yes</p> <p>Own <input type="checkbox"/> Yes</p>
<p><u>Diagnosis: (DSM) & Code</u></p> <p>1. _____ Code: _____</p> <p>2. _____ Code: _____</p> <p>3. _____ Code: _____</p> <p><u>Diagnosis: (DC 0-3) & Code</u></p> <p>1. _____ Code: _____</p> <p>2. _____ Code: _____</p> <p>3. _____ Code: _____</p>	<p><u>Functional Assessment</u></p> <p>Composite Score: _____</p> <p>Subscale Scores</p> <p>(Required when composite Score is < 2 s.d.)</p> <p>Communications: _____</p> <p>Social: _____</p> <p>Assessment Tool</p> <p>Name: _____</p>
<p>Description of Identified Need: (please attach additional sheets as needed)</p> <p><input type="checkbox"/> Yes child is aggressive</p> <p>Explain: _____</p>	



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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.	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Outpatient Tx	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Hospital	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Mobile Crisis	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Home Based Services	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Partial Hospital Program/IOP	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Crisis Unit	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Residential Tx	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
School/Preschool	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Other	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Family Preference

The Department is obligated to offer you the first available provider with an ability to begin service. You may identify a preferred provider but this provider may not be the first available to begin the service. Choosing a preferred provider may delay the start of service.

- No preference
- Preferred "Name of Provider" _____
- Please do not send information to the following provider's _____



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Signatures

Release of Information

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

Yes, I agree to release information contained within this application, and my child's RCS Comprehensive Assessment and Individual Treatment Plan, but only to receiving provider agencies as part of the treatment planning process.

Yes, I agree to release information contained within this application, and my child's RCS Comprehensive Assessment and Individual Treatment Plan, between my Target Case Manager and the receiving provider agencies as part of the treatment planning process.

No, I do not agree to release information contained within this application and my child's RCS Comprehensive Assessment and Individual Treatment Plan, to receiving provider agencies as part of the treatment planning process.

My signature below indicates my approval of the above statement

Parent/guardian: _____ Date: _____

Participation in the Service

Yes, I agree to participate with my child in this service.

No, I do not agree to participate with my child in this service.

My signature below indicates my approval of the above statement

Parent/guardian: _____ Date: _____

CBHS Website: <http://www.maine.gov/dhhs/ocfs/cbhs/index.shtml>

Fax Form to:

Region 1	Districts 1 & 2	DHHS/OCFS 161 Marginal Way, Portland, ME 04101 Fax: 207-822-2358 Att: Lisa Salger
Region 2	Districts 3, 4 & 5	DHHS/OCFS Attn: Sandy Barringer, 2 Anthony Avenue SHS #11 Augusta, ME 04333 Fax: 207- 624-7970
Region 3	Districts 6, 7 & 8	DHHS/OCFS, Attn: Ronda McGonigle, 396 Griffin Rd., Bangor, ME 04401 Fax: 207-561-4299