

# **Referral Instructions**

## **Children's Home and Community Base Treatment**

**Type of Service Requested:** Identify the service, if you can, which you think the child may need.

**Referral Source/Relationship:** identify the person who is requesting this service and their relationship to the child.

**Contact Information:** Record the name and contact information of the person completing the referral. This may be child's parent, guardian, caregiver, case manager or other service provider.

**Demographic Data:** Please complete this section as accurately and thoroughly as possible. It is important that the child's name is spelled correctly and as it appears on the MaineCare card. It is often helpful to double check the Social Security and MaineCare numbers after you have written them on the referral. Provide the address is where the child is currently living and where the child is able to receive services.

**Child's Primary language:** Please complete this section in regards to which assistance or language interpretation the child, family and or possible caregivers may need to communicate their needs and benefit from the service.

**Guardianship/Custody:** Complete this section identifying the current legal guardian(s) or the child is in DHHS state custody, this applies to Child Welfare V9 statuses for young adults.

**Primary Diagnosis:** Choose each disability category box that the child may be eligible for base on their diagnostic evaluation. If the child has a diagnosis of Mental Retardation (intellectual Disability), Autism, or PDD-NOS, the disability category will be MR/Autism. If the child has Aspergers or any other Mental Health diagnosis, the category will be MH. If the child has co-occurring disorders, both Mental Retardation (intellectual Disability) and mental health issues, then check both category boxes. If possible please write the name and code number of the diagnosis (es) of the child next to the areas that state Axis. If the child is under 4, the 0-3 Diagnostic Categories for diagnosis can be used if known.

**Reason for Referral:** Please provide as much information about and attempt to describe the child's problems and behaviors that have made it necessary to ask for services.

**Treatment History:** Please list any services the child or child and family have tried before seeking this service. Please include to the best of your ability the dates when other services were attempted.

**HCT within the Last 6 Months:** Please provide information about what has happened for this child and family over the last 6 months, if HCT had been tried before.

**Release of Information:** Parents/Guardian must initial questions (1-4) regarding the Release of Information, sign and date the form. The referral shouldn't be processed until a release of information is secured from the parent/guardian.

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