Crisis & Counseling Centers

Dedicated to Hope, Healing and Recovery
10 Caldwell Rd, Augusta, ME 04330-5735
Phone # 207-626-3448 Fax # 207-626-3453

REFERRAL FORM

Client Name: _____ **DOB:** _____ **Date:** _____

Gender: ☐Male ☐Female **Gender Identity:** ☐Male ☐Female ☐TGMale ☐TGFemale ☐Other

Address *(St/Rd/Apt#)*: _____ **Town/Zip:** _____

Mailing Address *(if different)*: _____

Phone *(please check preferred #)* ☐**Home #** _____ ☐**Cell #** _____

☐Leave non-identifying message with person/machine ☐Leave no message

Email Address _____

Guardian ☐Yes ☐No **If yes,** Name: _____ Phone # _____

Any Special Accommodations? _____

Permission to contact insurance for Prior Approval? ☐Yes ☐No

Primary Insurance: _____ **Policy ID#** _____

Secondary Insurance: _____ **Policy ID#** _____

Program being referred to: ☐Mental Health ☐Substance Use Disorder ☐Medication Management

Targeted Case Management: *(please specify only one)*

☐Children *(Behavior Health, Developmental Disabilities & Chronic Medical Care Needs)*
☐Parents *(with Substance Use Disorder diagnosis & minor children)*
☐PATH *(Projects for Assistance in Transition from Homelessness)*
☐OPTIONS *(Overdose Prevention Thru Intense Outreach, Naloxone and Safety)*

Preferred Site/Location: ☐Augusta ☐Rockland ☐Skowhegan

Referral Source: _____ **Phone #** _____

Reason for referral: *(Presenting Problem, Clinical Rationale, Diagnosis required for TCM referrals)* _____

_____

_____

_____

_____

Is the client currently receiving, or has received in the last year, any behavioral health services? ☐Yes ☐No

If yes, what service(s); agency(s); admit date(s); discharge date(s)? _____

_____

Currently has MAT Provider? ☐Yes ☐No **If yes,** provider/agency name? _____

Does client have any immediate safety concerns that may require immediate crisis services? ☐Yes ☐No

If yes, action taken? _____

Crisis number given? ☐Yes ☐No ***If no,*** *explain* _____

DHHS referrals only: *(Prior Authorization required for referrals)* **MACWIS #** _____

NPI Site # Augusta ☐MH-013 ☐SUD/IOP-014 Rockland ☐MH-025 ☐SUD-023 Skowhegan ☐MH-019 ☐SUD/IOP-018

Service Authorized	**# of Units/Timeframe**	**PA #**
☐Assessment-H2000	8 units / 30 days	CFS_____
☐Outpatient Tx-H0004	48 units/ 90 days	CFS_____
☐Intensive Outpatient-H0015	49 units/ 49 days	CFS_____