Case Management / BHH Referral Form

BHH available in Androscoggin, Franklin and Oxford Counties

Please fax the following information to: Referral Care Team **333-3037**

Service Requested: Adult CM ___ Child CM ___ BHH ___ Unsure __

Client Full Name: **Date of Birth:** **Gender: M /F** **Class Member: Y / N**

Address: **City:** **Zip:**

Home Phone: **Cell Phone:** **Permission to leave a message: Y / N**

Guardian name: **Home phone:** **Cell number:**

Interpreter Services needed: Client: Y / N Guardian: Y / N
Language spoken by client:

Referral source name: **Organization:** **Phone:**

Email: **How did you hear about us?:**

Diagnostic Information

If no current diagnosis – Assessment needed: Y / N

Current Diagnosis: _____ Date last seen for this diagnosis: _____

Diagnosing Clinician:_____

Current PCP: _____

Please Note: client will be discharged after 30 days if eligibility is not met. Transition services will be provided at that time.

Current Symptoms:

Service Needs:

Case Management preferences: Male / Female **Requesting:**

Safety concerns (Domestic Violence, Anger/Aggression): Y / N **Is the client in crisis? Y / N**
Substance Abuse: Y / N **Was crisis information given? Y / N**
Legal Issues: Y / N

Insurance Information

Mainecare Identification Number: **Social Security Number:**

Dual Provider issue: Y / N	***3 way call with client & APS made on: __/__/__***	***Issue Resolved: Y / N***

OFFICE USE ONLY		
Date Referral Received: __/__/__	**Date Insurance Verified: __/__/__**	**Initials:**
Full Mainecare: Y / N	**Case Manger Assigned:**	**Date:**

Please note: Insurance was verified on the date listed above through the Mainecare verification line. The clinician who accepts this referral assumes responsibility for verifying this information with the client and with Insurance Company at start of services and no less than once monthly.