TRI-COUNTY
MENTAL HEALTH SERVICES

REFERRAL

OUR MISSION:
Tri-County Mental Health Services is committed to providing the people of Maine with excellence in mental health, substance abuse, rehabilitation and life skills services, respecting consumer rights, personal dignity and maintaining agency financial stability.

SERVICES:
Tri-County Mental Health Services is one of Maine's most respected and progressive agencies dealing with the psychological and social well-being of children, adults, and elders. TCMHS serves over 10,000 individuals each year in Androscoggin, Northern Cumberland, Franklin and Oxford counties with innovative programs and services addressing mental health, substance abuse, mental retardation/developmental disabilities, autism, and more. The agency is a state, regional and national leader in trauma-informed and recovery-based service delivery, and strives to offer hope to individuals, families, and communities. Visit www.tcmhs.org for more information.

Referral Line for all Locations:	**1-888-304-HOPE (4673)**
TTY:	**1-888-568-1112**
Fax:	**1-207-783-4660**
STATEWIDE CRISIS SERVICES:	**1-888-568-1112**

Date of Referral: _____/_____/_________

Name of Person Being Referred (include any aliases:) ____

Date of Birth: _____/_____/__________ ___**Male** ___**Female**

Address: ____

City: ____ **State:**______ **Zip:** _______________

Home/Cell Phone: ________________________ **Work Phone:** ______________________

Is it OK to call home and leave a message that Tri-County Mental Health called: ( ) Yes ( ) No
Is it OK to call work and leave a message that Tri-County Mental Health called:: ( ) Yes ( ) No
Best time to call: _________________________

REASON FOR REFERRAL (provide brief summary:)

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RISK FACTORS:

Is the person you are referring having thoughts of hurting her/his self or somebody else at this time? ( ) Yes ( ) No

If yes, Please call the Statewide Crisis Intervention 24 hour Emergency Number: 1-888-568-1112
Crisis Referral Made to: _____________________________________ **Time of Contact:** ____________

Disposition:____

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Consent Decree: ( ) Yes ( ) No ( ) Unknown
(Persons who, on or after January 1, 1988, were patients at AMHI, or anyone who had been involuntarily confined at Pineland on or after July 3, 1975 or who had been conditionally released from Pineland and in a community placement on or after July 3, 1975 (with some exclusions.))

Consent Decree Status: ( ) AMHI ( ) Pineland ( ) Both AMHI and Pineland

INSURANCE/PAYSOURCE INFORMATION:

Insured Name: ( ) As Above ***or:*** ____________________________ **Insured SS #:** _________/______/_________

Insured DOB: ( ) As Above ***or:*** _____/_____/____________ **Relationship to Insured:** ( ) Self ***or:*** ____________

MaineCare #: ( ) None ***or:*** ____________________________ **Medicare #:** ( ) None ***or:*** _______________________

Insurance Co.: ( ) None ***or:*** ____________________________ **Certificate #:** ( ) None ***or:*** _____________________

Self Pay: ( ) Yes ( ) No Other (explain:) ____

REFERRAL SOURCE INFORMATION:

Referred by: ____

Agency/Provider Name: ____

Address: ____

City: ____ State: ________ Zip Code: ____________

Phone #: ____ Ext.__________

Is this person their own guardian? ( ) Yes ( ) No
If no, who holds guardianship?

Name: ____

Address:____State:_________Zip_____________

Phone:____

REQUESTED SERVICES:

Section 17 Services:
( ) Community Integration Services ( ) Adult ACT Services ( ) Intensive Community Integration
( ) Day Support Services

Specialized Children's Services:
( ) Child Case Management ( ) HBC/MST

Medication Management Services:
( ) Adult Medication Management ( ) Child Medication Management

Outpatient Services:
( ) Adult MH Outpatient ( ) Child Outpatient ( ) Geriatric Services ( ) Co-Occurring Services

Substance Abuse Services:
( ) Adult Drug Court ( ) Family Drug Court ( ) Substance Abuse Services

Interpreter needed? ( ) Yes ( ) No

Internal Use Only:

Signature of Staff Accepting Referral:

____ ____________________ _________________

Name Date Received Time Received