

OUR MISSION:

Tri-County Mental Health Services is committed to providing the people of Maine with excellence in mental health, substance abuse, habilitation 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

IN ORDER TO PROCESS YOUR REFERRAL IN A TIMELY MANNER PLEASE WE ASK THAT ALL FIELDS BE FILLED.

Date of Referral: ____/____/____

Name of person being referred: _____

Date of birth: ____/____/____ Male Female SS # _____

Address : _____

City : _____ State: _____ Zip: _____

Phone number: _____ Is it OK to leave messages? () Yes () No

REASON FOR REFERRAL:

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

INSURANCE/PAYSOURCE INFORMATION:

Name of Insurance Co: _____ Member ID #: _____

Name of policy holder: _____

Policy holder's DOB: _____ Relationship to Insured: _____

PARENTAL RIGHTS/GUARDIANSHIP:

Name of birth parent # 1: _____

Address: _____

Phone number: _____

Name of birth parent # 2: _____

Address: _____

Phone number: _____

Birth parents are: (choose one) Married/residing together Divorced/separated Unknown

If guardianship is held by someone other than the birth parent (OR)
the person you are referring is an adult with a guardian please include name and contact information of guardian:

REFERRAL INFORMATION:

Name of person referring: _____

Agency/ provider name: _____

Phone #: _____

REQUESTED SERVICES:

Adult Services:

- Outpatient Counseling CIS – Adult Case Management Adult ACT
- Day Support Services Medication Management Co-occurring counseling
- Substance Abuse counseling Drug court

Children’s Services:

- Outpatient counseling School based counseling - name of school: _____
- Case management School based case management – name of school: _____
- Multi-Systemic Treatment (MST)
- Multi-Systemic Treatment for Problem Sexual Behaviors (MST-PSB)
- Substance abuse counseling