

**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](http://www.tcmhs.org) for more information.

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

**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:**

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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:**

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, please include name and contact information of guardian:

\_\_\_\_\_

**REFERRAL INFORMATION:**

Name of person referring: \_\_\_\_\_

Referred by what school: \_\_\_\_\_

Phone #: \_\_\_\_\_

**REQUESTED SERVICES:**

**Specialized Children's Services:**

- School based Child Case Management
- School based Child Outpatient
- Multi-Systemic Treatment (MST)
- Multi-Systemic Treatment for Problem Sexual Behaviors (MST-PSB)