Date rec'd:

By:

Volunteers of America
Northern New England

Behavioral Health Services
Telephone: (207) 571-3255 Fax: (207) 282-0679
Email: danielle.huntington@voanne.org

MENTAL HEALTH SERVICES REFERRAL FORM

Today's Date: _____ Referred by: _____ Agency: _____ Phone: _____

TYPE OF SERVICE REQUESTING

☐PNMI/Residential	☐DLSS

IDENTIFYING INFORMATION

Name:		Class Member: ☐ yes ☐ no	Unique Identifier assigned: (VOA staff only)
Birth Date: / / Age:	Sex: ☐ M ☐ F ☐ TG	☐single ☐married ☐Divorced ☐separated ☐ veteran	
Current Address:		Mailing address (if different):	
Phone:	Next of Kin or contact person, address and phone:		
Occupation:	Employer/Day program:		
Highest level of education achieved:	Address:		Phone:
Legal Status: ☐own guardian ☐full public/private guardian ☐limited public/private guardian Describe:	Guardian Name:		
	Address:		Phone:

FINANCIAL

SS#			Maine Care ☐ yes ☐ no #:
Medicare ☐ yes ☐ no #			Medicare Part D ☐ yes ☐ no Provider:
Payee/Conservator Name: Address/Phone:			Employment Status:
Income Source	Amount	Frequency	Advanced directives on file ☐yes ☐no
			Life insurance
			Bank Accounts(s)

CONTACTS

Primary Care Phys:	Address/phone:
Psychiatrist/diagnosing clinician:	Address/phone:
Case Manager:	Address/phone:

PRESENTING PROBLEMS

Current Diagnosis, by:	***on (date):***
Diagnosis/Code	
Axis I ***Axis II*** ***Axis III***	***Axis IV*** ***GAF***

When, approximately, did these problems begin:

Signature of Diagnosing Clinician
(must be MD, LCSW, LMSW, LCPC, PHd, APRN, NPC or DO)

Date diagnosis administered
(must be made within the last 12 months)

PLEASE PRINT NAME AND CREDENTIAL

Agency/Facility/Practice

STRENGHTS/NEEDS

Briefly describe current STRENGTHS:

Briefly describe current NEEDS including consumer's and guardian's perspective:

Check all below that apply

☐Housing	☐Behavioral	☐Vocational	☐ Communication
☐Financial	☐ Food	☐ Social/interpersonal	☐Social Services
☐ Medical	☐Clothing	☐Family	☐Church/Spirituality
☐ Emotional	☐Transportation	☐ Criminal Justice	☐ Child Care
☐ Adaptive equipment	☐Speech/Hearing	☐ Sensory Integration	☐ Vision
☐ Dental	☐Nursing	☐ Chronic Illness	☐ Medication admin.
☐ Nutrition/dietary	☐Housekeeping	☐ Hygiene/personal care	☐ Phone/Corresp.
☐ Mobility	☐Memory	☐ Other healthcare	☐ Educational
☐ Advocacy/ understanding rights	☐Personal Safety	☐ Criminal Justice	☐ Sexuality

Likely to require crisis services? ☐yes ☐no

*Attach or request copy of current crisis plan if there is one.

Psychiatric/Psychological history (include when symptoms were first identified; previous

hospitalizations, crisis events; ability to access services needed etc.)

Therapy/Counseling:_____

Psychiatric Hospitalization:_____

Other:_____

Are you currently attending a self-help group? ☐ Yes ☐ No If yes, what:_____

Past and current drug/alcohol use

Substance Abuse Outpatient Counseling:_____

Substance Abuse Detoxification:_____

Substance Abuse Inpatient Rehabilitation:_____

VOA STAFF USE ONLY:

SCREENING AND ELIGIBILITY FOR SERVICE

SECTION 97 – Must be eligible for Mainecare, have a CSW and:		
☐age 18yrs or older	☐Axis I diagnosis* (severe and persistent)	☐Medications (self or supervised)
☐Current letter of medical necessity on file	☐Referral identifies how this service would benefit indiv.	☐Psychiatric hospitalizations (repeated or prolonged >1 yr)
☐Inability to function w/o intensive support or training	☐No suicidal/assaultive behavior for at least 30 days	☐ Eligibility for Maine Care verified
SECTION 17 – Must be Mainecare eligible. For CRS/DLSS the consumer must have an Axis I diagnosis* and at least one of the following risk factors. For CIS services must be a class member OR have one of the following:		
☐Has become homeless or is at risk of losing his/her current residence	☐is causing repeated disturbances in the community because of poor judgment, or bizarre, intrusive, or ineffective behavior.	☐Is at great risk of arrest because of behavior which results from his/her psychiatric diagnosis, or is presently incarcerated because of such behavior.
☐Presents a clear risk of harming self or others with Community Support Services.	☐Manifests great difficulty in caring for self, posing a threat to his/her life or limb, without Community Support Services.	☐Would deteriorate clinically to a point of needing immediate medical or psychiatric hospitalization in the absence of prompt Community Support Services.

*Please note that the primary diagnosis must be other than:
a. Delirium, dementia, amnesiac, and other cognitive disorders/
b. Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
c. Substance abuse or dependence;
d. Mental retardation;
e. Adjustment disorders; V-codes; or
f. Antisocial personality disorders.

Eligible ☐ **yes** ☐ **no** ☐**Accepted:** ☐PNMI/Residential ☐CRS ☐DLSS ☐CIS ☐**Wait list**

☐ response sent/date: ____________________ Signature: ____