



DHHS Referral

65 HCT

HOME AND COMMUNITY TREATMENT

Date Referral Received: _____

Type of Service Requested:

- 65 HCT
 FFT
 MST MST-PSB

Contact Information:

Individual Requesting Service: _____ Relation to Child: _____

Name (person completing form): _____ Agency: _____

Name of Children's Targeted Case Manager: _____

Office Location/Address: _____

Phone Number: _____ Ext: _____

Are there services already being provided in the child's home? Yes No

Demographics of Child (Child's name spelled as it appears on the MaineCare card)

First: _____ MI: _____ Last: _____ Gender: M F

DOB: _____ SSN: _____ Maine Care # _____ Race: _____ (optional)

Child's Current Residence (Legal Address where child will receive this service)

Street: _____

Town: _____ Zip: _____ Phone: _____

Childs Primary Language : _____ Caregivers Primary Language: _____

Does this family utilize interpreters services: yes No Name of Interpreter & contact information: _____

Legal Guardian(s) Name & mailing address

Phone # _____ Cell _____

Guardian(s) Custody

Married yes

Sole yes

Shared yes fill in name/address



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<u>Shared Custody</u> Name & mailing address	
Phone #	Cell

<u>Primary Diagnosis</u> <input type="checkbox"/> MR/Autism <input type="checkbox"/> MH <input type="checkbox"/> EI/DD		
Axis I	Axis II	D/C 0-3

<u>Reason for Referral/Presenting Problem</u> i.e. why now? (Please include primary symptoms/behaviors, frequency, intensity, duration)

<u>Treatment History</u> Should reflect that lower level services have been attempted and were ineffective.		
Service	Dates	Reason for Discharge

If member/family was enrolled in 65 HCT service within the last 6 months please provide information regarding other service accessed, barriers to progress, what has changed, and how service is expected to benefit family at this time.

Please indicate primary goal of treatment and Estimated Length of Stay



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Release of Information

In order for Treatment to proceed the following Parental/Guardian Approval must be granted. (Please initial after each statement and sign below in Parent/Guardian section)

As the parent/guardian of this child (or self, when own guardian),

1. I agree with the proposed intensive in home child and family treatment service. _____
2. I agree to actively participate in this treatment that includes: family meetings, family therapies, individual therapy, as indicated. _____
3. I agree to the release of the information contained within this application, but only to a receiving provider agency as part of the treatment planning process. _____
4. I have reviewed all information contained in this document and attest that it is true to the best of my knowledge.

My signature below indicates my approval of all the above-initialed statements.

Parent/Guardian:

Date:

*** It is highly recommended to attach the child's most recent Diagnostic Evaluation to speed up the process.**