

**Referral Form**

If you or someone you know would benefit from assistance with strengthening their emotional health, physical health and support network as well as increasing their access and connection to community resources, please complete the referral information below and fax it to us at 871-7457. If there is need for more immediate assistance, please walk-in to (66 State Street, Portland, 3rd Floor) or call (871-7431) and our Community Response provider can schedule a same day appointment with you. Community Office hours are Monday -Friday 8:30 a.m. to 4:30 p.m.

**Referent**

|  |  |
| --- | --- |
| Date: | Date Referral Received: |
| Referent: | Referent Contact #: |
| Referent Agency: | Referent Email: |

**Individual Seeking Services**

|  |  |
| --- | --- |
| Name: | DOB: |
| Social Security #: | Contact #: |
| Address: | City/Zip Code: |
| Email: | Mainecare #: |
| Which program is the individual seeking support from? \_\_\_\_ ACT \_\_\_\_ BHH \_\_\_Other: | |
| Current DSM V Diagnosis: | |
| PCP Name: | PCP Contact #: |

*If the individual does not have Mainecare, we will provide assistance with completing and submitting the application at their initial appointment.*

Is the individual currently enrolled in services with Catholic Charities of Maine? \_\_\_\_\_Yes \_\_\_\_\_ No

If yes, please list the services they are enrolled in:

**For provider referrals, please submit a current diagnosis and signed Consent for Release of Information with this form.**

What supports would be most helpful to the individual seeking services (check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_ Housing | \_\_\_\_ Employment | \_\_\_\_ Education | \_\_\_\_ Financial Support |
| \_\_\_\_ Counseling | \_\_\_\_ Substance Use | \_\_\_\_ Medication | \_\_\_\_ Nutrition |
| \_\_\_\_ Mobility | \_\_\_\_ Food Access | \_\_\_\_ Dental Care | \_\_\_\_ Coping Skills |
| \_\_\_\_ Healthy Lifestyle | \_\_\_\_ SSI/SSDI | \_\_\_\_ Support Network | \_\_\_\_ Childcare |
| \_\_\_\_ Other: (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |