Woodfords Family Services Behavioral Health Homes Services
Referral Form

Name of Child: ____

DOB: _________________ Sex:______________

Child's diagnosis:____

Does child have Mainecare/Katie Beckett:___________________________________

MC#:__________________ SS#:___________________ Date of referral: _________

Child/family needs for Behavioral Health Home Services:

____

____

Symptoms/Behaviors:

____

____

Parent/Guardian name: ____

Parent email address:

Parent/Guardian phone number:____

Parent/Guardian mailing address: ____

Parent/Guardian physical address: __________________________________Apt. #____

Name of school child attends: ____

Name of school contact for this child: ______________________________________

Person making this referral /relation to child: ________________________________

Is an interpreter needed? **No** **Yes - language:** ____________________________

Providers:

Name of PCP/Practice: ____

Other Providers: (e.g., CDS, MMP Pediatric Specialty Group, Psychiatrist, Counselor)

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____

In-Home Support Agency: ____

Current or Past CCM/BHH agency: ____

Guardianship paperwork needed for file? **No** **Yes**

Revised 8/1/18