Woodfords Family Services Behavioral Health Homes Services
Referral Form

Name of Child: _____ Date of Referral: _____

DOB: _____ Sex:_____

Child's diagnosis:_____

Does child have Mainecare/Katie Beckett: ☐ Yes ☐ In the Process of Applying
***Child must have active MaineCare to access BHH Services** ☐ No - Needs Assistance Applying

MC#:_____

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)

_____

_____

_____

In-Home Support Agency: _____

Current or Past CCM/BHH agency: _____

Guardianship paperwork needed for file? ☐ **No** ☐ **Yes - Included**

Fax or Email Completed Form to: 877-298-4491 OR Intake@woodfords.org