OCMHS
Referral and Demographics

Date:

Name: **Phone Number(s):**
Preferred Name or Nickname:
If unable to contact me directly, it is ok to leave a message at the phone number/s that I provided:
Yes ___ No ___

Reason(s) for referral/services requested:

This referral is for the following services, check all that apply

- ☐ Case Management
- ☐ Outpatient Therapy
- ☐ Substance Abuse
- ☐ School-based Therapy - Name of School _____
- ☐ Dialectical Behavioral Therapy (DBT)
- ☐ Behavioral Health Home (MaineCare Recipients ONLY)
- ☐ Driver Education and Evaluation Program (DEEP)

Physical Address:
Town: ZIP:

Mailing Address:
Town: ZIP:

DOB: Age: Gender: Social Security #

Parent/Legal Guardian: Phone Number(s):

Address:
Town: ZIP:

Do you have a relative who works for OCMHS? Yes____ No____
If so, who?

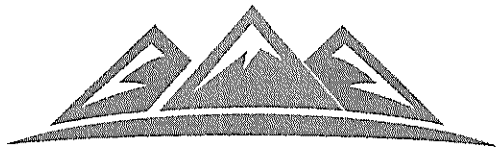
Are you able to climb stairs? Yes____ No____

Are you a Class Member Yes ____ No _____ (A Class Member is a person who was hospitalized at AMHI/Riverview prior to 1990)

Name and Agency of person making the referral, if other than self:
Is the potential client aware of this referral? Yes ____ No ___

150 Congress Street
Rumford, Maine 04276
Phone: 364-3549
Fax: 364-2143

17 Gary Street
South Paris, Maine 04281
Phone 739-7001
Fax: 743-2999



OCMHS

Ethnicity: __African American __Asian __Caucasian __Hispanic __Native American __Other: _____

Marital Status: __Divorced __Separated __Domestic Partner __Widowed __Married __Single

Smoking Status: __Current Smoker __Former Smoker __Never Smoked

Primary Language: __English __Sign Language __French __Somali __Spanish __Other: _____ Interpreter Needed? __Yes __No

Employment Status: __Employed Full Time __Employed Part Time __Student __Unemployed-Seeking __Unemployed-Not seeking __Disabled Job Title: _____

Level of Education: _____ **Vocational Training**: _____

Annual Household Income: _____**# of Individuals in Home**: ___ **# Under Age of 18**:_

Primary Source of Income: __Alimony __Child Support __Family __Savings/Investments __Wages/Salary __SSI __SSDI

Do you have Mainecare? Yes ___ No ___ Maine Care #:

Do you have Medicare? Yes____ No ____ Medicare #:

Will you be paying out of pocket for the service/s? Yes ___ No ___
If Yes, please call 207-364-3549 to discuss sliding scale options.

Do you have private health insurance? Yes ____ No _____

If so, does your insurance cover this type of service? Yes ____ No ____

Name of Private Health Insurance Company:

Address: Phone number:

Subscriber's Name: Relationship to client:

Policy Number: Group Number:

Please Provide a copy of your insurance card

For any external providers, please complete a Release of Information Form

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