

Date Received: _____

Date Entered: _____

Wings for Children and Families, Inc.

Five County Regional Provider Referral Form

(Aroostook, Penobscot, Hancock, Piscataquis and Washington)

Wings, Catholic Charities Maine St. Michael's Center and the Department of Health and Human Services Children's Behavioral Health Services conduct an integrated intake process

YOUTH INFORMATION

Today's Date: _____

First: _____ Middle: _____ Last: _____

Youth's Date of Birth: _____ Age: _____ Gender: M F

Youth's Social Security Number: _____

Is the youth receiving MaineCare? Yes No Will apply Has applied Denied

Youth's MaineCare Number: _____

Parent(s)/Guardian: _____

Phone Number Where We Can Reach Parent/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Is youth currently residing at above location? Yes No

If not, describe youth's current placement/living situation: _____

PROVIDER INFORMATION

Name of Provider Filling out Referral: _____

Agency/Organization/Dept: _____

Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Is the family aware of this referral? YES NO

NOTE: Wings is a voluntary service. Activation of referral is dependent on contact with legal guardian/parent confirming their wishes to receive case management services from Wings for Children and Families. If we do not hear from family, we will try to contact family by telephone and letter.

Diagnosis Information

In order for youth to receive targeted case management services, there must be verification of a DSM-IV Axis I or Axis II diagnosis from a qualified provider. The diagnosis verification should include the diagnosis, DSM-IV-TR diagnosis code, evaluator name and credentials, and date evaluated (diagnostic evaluation should not exceed three years).

Diagnosis: _____ Code: _____

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Diagnosis: _____ Code: _____

Diagnosis: _____ Code: _____

Evaluator Name: _____

Date Diagnosed: _____

Is the Department of Corrections/Juvenile Probation involved? No Yes
(if yes, please briefly explain)

Is the Department of Human Services Child Protective Services involved? No Yes
(if yes, please briefly explain)

Please describe services family is currently receiving, such as respite, behavioral specialist services, case management, other in-home services, etc...

Reason for referral/current situation:

To expedite referral, enclose copy of recent evaluation with DSM-IV-TR Diagnosis and Code from a qualified provider.

Please mail or FAX this form and evaluation to:

Wings for Children and Families
900 Hammond Street Suite 915
Bangor, Maine 04401
FAX (207) 941-2989

Phone: (207) 941-2988 OR Toll-free 1-800-823-2988