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| **Referral**  MaineCare Section 65  Home and Community-Based Treatment (HCT) |

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| Please specify: | |
|  | HCT- No Preferred Provider |
|  | HCT- Preferred Provider Requested |
|  | (if selecting preferred provider, please see page 3) |
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Referral must include:

**Signed Authorization to Release Information Form**

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| **Referral Contact Information** | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | Agency: | | |  | | | |
| (Person completing form) Are you the case manager: | | | | | | | | | | Yes  No | | | | | |
| Office Location/Address: | | | |  | | | | | | | | | | | |
| Agency/Facility NPI Number: | | | | |  | | | | | | | | | | |
| Phone Number: | | |  | | | | Ext: | | | |  | | | | |
| Fax Number: | |  | | | | Email: | |  | | | | | | |  |
| Signature of person completing form: | | | | | |  | | | | | | | Date: |  |  |
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| **Child Information:**  Name(as it appears on the MaineCare Card) | | | | | | | | | | | | | | | |
| First: |  | | | MI: | | |  | | Last: | | |  | | | |
| Gender | Male | Female | | | Race (optional): | | | | | |  | | | | |
| DOB: |  | SSN: |  | | | | | Maine Care #: | | | |  | | | |
| **Legal address where child will receive services** | | | | | | | | | | | | | | | |
| Street: |  | | | | | | | | | | | | | | |
| City/Town: |  | | | | | State | |  | | Zip: | | |  | Phone: |  |
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| **Child’s Primary Language**: | | | | |
| Caregiver’s Primary Language: | | |  | |
| Does the family utilize interpreter services: | | | Yes No | |
| Name of the interpreter & contact information: | | |  | |
|  | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Legal Guardian(s)** Name & mailing address | | | | |  | | | | |  | | | | |  | | | | | Phone #: |  | Cell: |  | | **Shared Custody** Name & mailing address | | | | |  | | | | |  | | | | |  | | | | | Phone #: |  | Cell: |  | | | |  |  | | --- | --- | | **Guardian(s) Custody** | | | Married | Yes | | Sole | Yes | | Shared | Yes | | Name/Address under Shared Custody | | | DHHS | Yes | | Own | Yes | | |
| **Primary Reason for referral: (**please attach additional sheets as needed to include *frequency, intensity, and duration of symptoms and behaviors)* | | | | | |
| 1. **Is the member receiving Outpatient Services?  Yes  No**     1. **If yes, please describe how the members’ needs are not being met that the level. If no, please discuss why HCT level is required.** 2. **Has the member had HCT in the home within six (6) months?  Yes  No**     1. **If yes, please discuss why sustainable progress has not been made.** 3. **Has the child been involved in the Juvenile Justice System?  Yes  No**    1. **(If yes please explain)**      1. **Is the youth at risk for out of home treatment or transitioning home from an out of home treatment?  Yes  No**     1. **(If yes please explain)** 2. **Has the child been suspended or expelled from childcare and/or an educational setting?**   **Yes  No**   * 1. **(If yes please provide the date)**  1. **Is the member’s need for service primarily due to their Intellectual Disability/Developmental Disability diagnosis?  Yes  No** 2. **When is the family available to be served?**  **Morning**  **Afternoon**  **Evening** 3. **Is member interested in telehealth?  Yes  No** 4. **Does member have technology to participate in telehealth?  Yes  No** 5. **Is member open to telehealth for some of the service or all of the service?** 6. **Some of the service**  **All of the service** | | | | | |

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| 1. **Is this request a result of remote learning?  Yes  No**     1. **Please explain:** |
| 1. **Is member/family interested in clinician only HCT services?  Yes  No** |

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| Family Preference |
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| You may identify one Preferred Provider, but this provider may not be the first available to begin the service. Please select if you would like to wait for the Preferred Provider or work with the first available Provider, and initial (Guardian) |
| I would like to wait for a Preferred Provider. \_\_\_\_\_\_\_\_\_\_\_ (initials) Preferred Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I will work with the first available Provider. \_\_\_\_\_\_\_\_\_\_\_ (initials)  Please do not send information to the following providers |

Upload the Referral and Signed Authorization to Release Information Form in the Acentra Health Atrezzo Provider Portal.

For instructions on how to submit via the portal, please visit [www.qualitycareforme.com](http://www.qualitycareforme.com).

To obtain a copy of the Authorization to Release Information Form, please visit <https://www.maine.gov/dhhs/privacy>.

Fax (866) 325-4752