

## Questionnaire: Referral Management

### Referral

**Instructions: \*\*\*IMPORTANT!!!** In selecting SECTION 28, please make sure you are selecting the correct type. Please take careful note of the HOME BASED and SCHOOL BASED options, and select the correct one\*\*\*

1. Select the type of referral:

(Please select one.)

- |   |  |
|---|--|
| <input type="checkbox"/> Section 13 Targeted Case Management (TCM) Services             | <input type="checkbox"/> Section 17 Community Support Services   |
| <input type="checkbox"/> Section 28 Rehabilitative and Community Support (RCS) Services | <input type="checkbox"/> Section 28 Rehabilitative and Community Support (RCS) Services (School-Based) |
| <input type="checkbox"/> Section 65 Home and Community Based Treatment (HCT) Services   | <input type="checkbox"/> Section 65 Medication Management  |
| <input type="checkbox"/> Section 92 Behavioral Health Home (BHH) Services               | <input type="checkbox"/> Section 97 Intensive Temporary Residential Treatment (ITRT) Services          |
| <input type="checkbox"/> Section 97 Children's Residential Care Facilities (CRCF)       |  |

If you answered "Section 13 Targeted Case Management (TCM) Services" on question 1

1.1.1. Indicate the referent's name, email address, and phone number:

1.1.2. Date of referral:

If you answered "Section 17 Community Support Services" on question 1

1.2.1. Indicate the referent's name, email address, and phone number:

**Instructions:** To be entered as a referral for Non-MaineCare, the member must not have active MaineCare.

1.2.2. Indicate if the referral is for a MaineCare Funded service or a Non-MaineCare Funded (also known as Grant-Funded) service:

(Please select one.)

- ☐ MaineCare Funded  
☐ Non-MaineCare (Grant Funded)

If you answered "Section 28 Rehabilitative and Community Support (RCS) Services" on question 1

**Instructions:** Please enter in one referral per service.

1.3.1. Type of Section 28 service:

(Please select one.)

- ☐ Non-specialized  
☐ Specialized

**Instructions:** The Functional Assessment Scores do not need to be uploaded.

1.3.2. Are you submitting Functional Assessment Scores?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.2

**Instructions:** The Functional Assessment Scores do not need to be uploaded.

1.3.2.1.1. Composite Score:

**Instructions:** The Functional Assessment Scores do not need to be uploaded.

1.3.2.1.2. Communications/Conceptual:

**Instructions:** The Functional Assessment Scores do not need to be uploaded.

1.3.2.1.3. Social:

**Instructions:** The Functional Assessment Scores do not need to be uploaded.

1.3.2.1.4. Assessment Tool Used:

**Instructions:** The Functional Assessment Scores do not need to be uploaded.

1.3.2.1.5. Name and credentials of who completed the assessment:

1.3.3. Date of Functional Assessment:

**Instructions:** If you have an MD letter, please upload it to the case.

1.3.4. Are you submitting a MD letter?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.4

**Instructions:** If you have an MD letter, please upload it to the case.

1.3.4.1.1. Physician's name and credentials:

1.3.5. Reason for referral (Please include symptoms and behaviors (frequency, intensity, and duration) that support the level of care requested):

1.3.6. Has the child been suspended or expelled from child care and / or an educational setting?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.6

1.3.6.1.1. Provide the date:

1.3.7. Is the member's current need for service primarily due to their Intellectual Disability/Developmental Disability diagnosis?

(Please select one.)

- ☐ Yes  
☐ No

1.3.8. Is this request a result of remote learning?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.8

1.3.8.1.1. Please explain

1.3.9. When is the family available to be served?

(Please select between 1 and 3 items.)

- ☐ Morning  
☐ Afternoon  
☐ Evening

1.3.10. Has the child been involved in the Juvenile Justice System? (If yes, please provide dates)

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.10

1.3.10.1.1. Please Explain:

1.3.11. Does this member have a guardian?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.11

1.3.11.1.1. Last guardian name and phone number:

1.3.12. Does the family have a preferred provider?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.12

1.3.12.1.1. Select the Specialized Section 28 Preferred Provider:

(Please select one.)

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> ABC Behave                            | <input type="checkbox"/> Best Divisi & Associates                             | <input type="checkbox"/> CARD- Center for Autism & Related Disorders | <input type="checkbox"/> CASA, Inc.                             | <input type="checkbox"/> Compass Behavioral Health |
| <input type="checkbox"/> Connections for Kids                  | <input type="checkbox"/> COR Health Services                                  | <input type="checkbox"/> Counseling and Trauma Therapy Associates    | <input type="checkbox"/> Discovering Kids Consultation Services | <input type="checkbox"/> Downcast Maricopa, Inc.   |
| <input type="checkbox"/> Eastern Maine Counseling and Training | <input type="checkbox"/> E.C.C.O., LLC  | <input type="checkbox"/> Innovations Behavioral Services             | <input type="checkbox"/> Mark R. Hammond, Inc.                  | <input type="checkbox"/> Pathways                  |
| <input type="checkbox"/> R.I.S.E., INC                         | <input type="checkbox"/> Sequel Care  | <input type="checkbox"/> Sunrise Opportunities                       | <input type="checkbox"/> Woodfields                             | <input type="checkbox"/> The Northern Lighthouse   |
| <input type="checkbox"/> UCP of Maine                          | <input type="checkbox"/> Woodfields (all counties except Cumberland and York) |  |   |  |

1.3.12.1.2. Select the Non-Specialized Section 28 Preferred Provider:

(Please select one.)

- |   |   |  |  |   |   |   |  |   |   |   |   |   |
|---|---|--|--|---|---|---|--|---|---|---|---|---|
| <input type="checkbox"/> 10 Forward Programs for Families and Communities | <input type="checkbox"/> ABC Behave, LLC            | <input type="checkbox"/> Adam Healthcare Services, LLC | <input type="checkbox"/> Addison Pointe Specialized Services, Inc. | <input type="checkbox"/> Affinity                             | <input type="checkbox"/> Aroostook Home Health Services   | <input type="checkbox"/> Aspire Behavioral Health & Counseling- Home Hope & Healing | <input type="checkbox"/> Back To Basics Behavioral Health Services, Inc. | <input type="checkbox"/> Bangor Counseling Center           | <input type="checkbox"/> Behavioral Health Solutions for ME   | <input type="checkbox"/> Black Bear Support Services, LLC                     | <input type="checkbox"/> Best Divisi & Associates               | <input type="checkbox"/> Bridges of Maine, LLC                    |
| <input type="checkbox"/> Bright Future Healthier You                      | <input type="checkbox"/> Care & Comfort             | <input type="checkbox"/> Catcha Falling Star           | <input type="checkbox"/> Central Aroostook Association             | <input type="checkbox"/> Choices Are for Everyone, Inc (CAFE) | <input type="checkbox"/> Christian Dawn Counseling Center | <input type="checkbox"/> CASA, Inc.   | <input type="checkbox"/> Compass Behavioral Health                       | <input type="checkbox"/> Connections for Kids               | <input type="checkbox"/> Community Care                       | <input type="checkbox"/> COR Health Services                                  | <input type="checkbox"/> Discovering Kids Consultation Services | <input type="checkbox"/> Counseling and Trauma Therapy Associates |
| <input type="checkbox"/> Counseling and Trauma Therapy Associates         | <input type="checkbox"/> Downcast Maricopa, Inc.    | <input type="checkbox"/> E.C.C.O., LLC                 | <input type="checkbox"/> Essential Learning Solutions              | <input type="checkbox"/> Freedom First Support Services       | <input type="checkbox"/> Galant Therapy Services          | <input type="checkbox"/> Gateway Community Services                                 | <input type="checkbox"/> Growing Opportunities, Inc.                     | <input type="checkbox"/> Innovation Behavior Services       | <input type="checkbox"/> Living Innovations Support Services  | <input type="checkbox"/> Maine Behavioral Health Organization                 | <input type="checkbox"/> Maine Immigrant and Refugee Services   | <input type="checkbox"/> Maine Immigrant and Refugee Services     |
| <input type="checkbox"/> Mark R. Hammond Associates, Inc.                 | <input type="checkbox"/> MAS Community Health       | <input type="checkbox"/> MC Community Services         | <input type="checkbox"/> Minds for Health, LLC                     | <input type="checkbox"/> Mobius, Inc.                         | <input type="checkbox"/> New Mainer Public Initiative     | <input type="checkbox"/> Northeast Occupational Exchange                            | <input type="checkbox"/> Northern Maine General                          | <input type="checkbox"/> North Shore Behavioral Health, LLC | <input type="checkbox"/> Penquis                              | <input type="checkbox"/> Pine Tree Society                                    | <input type="checkbox"/> Reset Behavioral Health                | <input type="checkbox"/> Progressions Behavioral Health Services  |
| <input type="checkbox"/> Reset Behavioral Health                          | <input type="checkbox"/> Saco River Health Services | <input type="checkbox"/> Sequel Care of Maine          | <input type="checkbox"/> Sunrise Opportunities                     | <input type="checkbox"/> The Northern Lighthouse              | <input type="checkbox"/> The Progress Center              | <input type="checkbox"/> Two Caps Vocational Services- STRIDE                       | <input type="checkbox"/> UCP of Maine                                    | <input type="checkbox"/> Watch Me Shine, Inc.               | <input type="checkbox"/> Western Maine Behavioral Health, LLC | <input type="checkbox"/> Woodfields (all counties except Cumberland and York) | <input type="checkbox"/> Woodfields Family Services             | <input type="checkbox"/> Woodfields Family Services               |

1.3.13. Have you explored Multi Systemic Therapy (MST) or Functional Family Therapy (FFT) services?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.13

1.3.13.1.1. What service was explored?

1.3.13.1.2. When did you refer the member to this service?

If you answered "No" on question 1.3.13

1.3.13.2.1. Why was the member not referred to these services?

1.3.14. Are there any providers the family does not want information sent to?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.14

1.3.14.1.1. Indicate the provider(s):

1.3.15. Is member interested in telehealth?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.15

1.3.15.1.1. Does member have technology to participate in telehealth?  
(Please select one.)

- ☐ Yes  
☐ No

1.3.15.1.2. Is the member open to telehealth for some of the service or all of the service?

- (Please select one.)  
☐ Some of the service  
☐ All of the service

1.3.16. Does the member require an interpreter?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.3.16

1.3.16.1.1. What language and dialect will the interpreter need to know?

1.3.17. Will the child receive services at the address currently specified on the patient detail page?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "No" on question 1.3.17

1.3.17.2.1. List the address:

1.3.17.2.2. Select City:  
(Please select one.)

- ☐ Abbot  
☐ Acton  
☐ Adamsville Top  
☐ Addison  
☐ Albany Top  
☐ Alamo  
☐ Alexander  
☐ Alfred  
☐ Alhambra  
☐ Aliso  
☐ Alton  
☐ Ambrose  
☐ Amity  
☐ Anderson  
☐ Anson  
☐ Appleton  
☐ Apple Top  
☐ Arcadia  
☐ Arandale  
☐ Ashland  
☐ Ashburn  
☐ Ashburn  
☐ Auburn  
☐ Augusta  
☐ Aurora  
☐ Avon  
☐ Bailey Island  
☐ Baileyville  
☐ Bancroft



- [illegible]

- [illegible]

- [illegible]





- [illegible]

- [illegible]

- [illegible]

1.3.18. ReferralProvider.NPI.Number

1.3.19. Indicate the referent's name, email address, and phone number.

If you answered "Section 28 Rehabilitative and Community Support (RCS) Services (School-Based)" on question 1

**Instructions:** Please enter in one referral per service.

1.4.1. *Type of Section 26 service:*

- (Please select one.)
- ☐ Non-specialized
  - ☐ Specialized

Instructions: The Functional Assessment Scores do not need to be uploaded.

1.4.2. *Are you submitting Functional Assessment Scores?*

- (Please select one.)
- ☐ Yes
  - ☐ No

If you answered "Yes" on question 1.4.2

Instructions: The Functional Assessment Scores do not need to be uploaded.

1.4.2.1.1. *Composite Score:*

Instructions: The Functional Assessment Scores do not need to be uploaded.

1.4.2.1.2. *Communications/Conceptual:*

Instructions: The Functional Assessment Scores do not need to be uploaded.

1.4.2.1.3. *Social:*

Instructions: The Functional Assessment Scores do not need to be uploaded.

1.4.2.1.4. *Assessment Tool Used:*

Instructions: The Functional Assessment Scores do not need to be uploaded.

1.4.2.1.5. *Name and credentials of who completed the assessment:*

1.4.3. *Date of Functional Assessment:*

Instructions: If you have an MD letter, please upload it to the case.

1.4.4. *Are you submitting a MD letter?*

- (Please select one.)
- ☐ Yes
  - ☐ No

If you answered "Yes" on question 1.4.4

Instructions: If you have an MD letter, please upload it to the case.

1.4.4.1.1. *Physician's name and credentials:*

1.4.5. *Reason for referral (Please include symptoms and behaviors (frequency, intensity, and duration) that support the level of care requested):*

1.4.6. *Has the child been suspended or expelled from child care and/or an educational setting?*

- (Please select one.)
- ☐ Yes
  - ☐ No

If you answered "Yes" on question 1.4.6

1.4.6.1.1. *Provide the date:*

1.4.7. *Is the member's current need for service primarily due to their Intellectual Disability/Developmental Disability diagnosis?*

- (Please select one.)
- ☐ Yes
  - ☐ No

1.4.8. *When is the family available to be served?*

- (Please select between 1 and 3 items.)
- ☐ Morning
  - ☐ Afternoon
  - ☐ Evening

1.4.9. *Has the child been involved in the Juvenile Justice System? (If yes, please provide dates)*

- (Please select one.)
- ☐ Yes
  - ☐ No

If you answered "Yes" on question 1.4.9

1.4.9.1.1. *Please Explain:*

1.4.10. *Does this member have a guardian?*

- (Please select one.)
- ☐ Yes
  - ☐ No

If you answered "Yes" on question 1.4.10

1.4.10.1.1. *List guardian name and phone number:*

1.4.1.1. Are there any providers the family does not want information sent to?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.4.1.1

1.4.1.1.1. Indicate the provider(s):

1.4.1.2. Have you explored Multi Systemic Therapy (MST) or Functional Family Therapy (FFT) services?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.4.1.2

1.4.1.2.1. Which service was explored?

1.4.1.2.2. When did you refer the member to this service?

If you answered "No" on question 1.4.1.2

1.4.1.2.1. Why was the member not referred to these services?

1.4.1.3. Does the member require an interpreter?

(Please select one.)  
☐ Yes  
☐ No

If you answered "Yes" on question 1.4.1.3

1.4.1.3.1. What language and dialect will the interpreter need to know?

1.4.1.4. Is member interested in telehealth?

(Please select one.)  
☐ Yes  
☐ No

If you answered "Yes" on question 1.4.1.4

1.4.1.4.1. Does member have technology to participate in telehealth?

(Please select one.)  
☐ Yes  
☐ No

1.4.1.4.2. Is the member open to telehealth for some of the service or all of the service?

(Please select one.)  
☐ Some of the service  
☐ All of the service

1.4.1.5. Does member have technology to participate in telehealth?

(Please select one.)  
☐ Yes  
☐ No

1.4.1.6. Is the member open to telehealth for some of the service or all of the service?

(Please select one.)  
☐ Some of the service  
☐ All of the service

1.4.1.7. Is this request a result of remote learning?

(Please select one.)  
☐ Yes  
☐ No

If you answered "Yes" on question 1.4.1.7

1.4.1.7.1. Please explain

1.4.1.8. Will the child receive services at the address currently specified on the patient detail page?

(Please select one.)  
☐ Yes  
☐ No

If you answered "No" on question 1.4.1.8

1.4.1.8.1. List the address

1.4.1.8.2. Select City:  
(Please select one.)  
☐ Alaska  
☐ Arizona

- ☐ Adams-on-Twp
- ☐ Addison
- ☐ Albany Twp
- ☐ Allen s
- ☐ Alondorf
- ☐ Alfred
- ☐ Allgates
- ☐ Alma
- ☐ Allen s
- ☐ Amburst
- ☐ Amity
- ☐ Andover
- ☐ Anson
- ☐ Appleton
- ☐ Appleby Twp
- ☐ Arno vale
- ☐ Avenel
- ☐ Ashland
- ☐ Athens
- ☐ Atkinson
- ☐ Auburn
- ☐ Augsburg
- ☐ Aurora
- ☐ Avon
- ☐ Baily Island
- ☐ Bailyville
- ☐ Bancroft
- ☐ Bangor
- ☐ Bar Harbor
- ☐ Bar Mills
- ☐ Barrington Pk
- ☐ Barnard Twp
- ☐ Barre Harbor
- ☐ Bath
- ☐ Bath
- ☐ Beaver Cove
- ☐ Beedingten
- ☐ Belham
- ☐ Belgrade
- ☐ Belgrade Lakes
- ☐ Belgrade Lks
- ☐ Belmont
- ☐ Benndicta
- ☐ Benton
- ☐ Bernard
- ☐ Bernwick
- ☐ Bethel
- ☐ Biddeford
- ☐ Biddeford Pl
- ☐ Biddeford Pool
- ☐ Big Lake Twp
- ☐ Bingham
- ☐ Birch Harbor
- ☐ Birch Island
- ☐ Blaine
- ☐ Blanchard Twp
- ☐ Boe-Heyay
- ☐ Boe-Heyay Harb
- ☐ Boe-Heyay Har
- ☐ Bowdoin
- ☐ Bowdoinhum
- ☐ Bowcorunk
- ☐ Bradford
- ☐ Bradley
- ☐ Bremen
- ☐ Brewer
- ☐ Bridgewater
- ☐ Bridgeport
- ☐ Brighton Pk
- ☐ Bristol
- ☐ Brookden
- ☐ Brooks
- ☐ Brooksville
- ☐ Brooksville Junction
- ☐ Brunswick Jct
- ☐ Brunswick
- ☐ Bryant Pond
- ☐ Buckfield
- ☐ Bucks Harbor
- ☐ Bucaport
- ☐ Burlington
- ☐ Burnham
- ☐ Bustins Is
- ☐ Bustins Island
- ☐ Buten s
- ☐ Byron
- ☐ Cabot
- ☐ Cambridge
- ☐ Camden
- ☐
- ☐ Canton
- ☐ Cape Cottage
- ☐ Cape Eke
- ☐ Cape Elizabeth

- [illegible]

- Deer Pt
- Des Moines
- Dyer Brook
- E Blue Hill
- E La Crosse
- E Milwaukee
- E Menomonee Twp
- E Packerfield
- E Stoughton
- E Vanalstene
- E Watertown
- East Baldwin
- East Blue Hill
- East Bonoboy
- East District
- East Holden
- East Litchmore
- East Machias
- East Milline dot
- East Menic Twp
- East Newport
- East Orland
- East Packerfield
- East Poland
- East Vanalstene
- East Watertown
- East Wilton
- East Windsor
- Eastbrook
- Easton
- Eastport
- Essex Cove Twp
- Edgington
- Edgewood
- Edinburg
- Edmunds Twp
- Ellet
- Ellettsville Twp
- Ellettsville Twp
- Ellsworth
- Emblem
- Emfield
- Essexport Sta
- Essexport Station
- Ena
- Ennis
- Enston
- Enfield
- Falmouth
- Farmington
- Farmington Fls
- Farmington
- Farmington Falls
- Fayette
- Fishers Landing Twp
- Fishers Ldg
- Forest City Twp
- Forest Twp
- Fert Fairfield
- Fert Kent
- Fert Kent Mills
- Frankfort
- Franklin
- Frankton
- Frankton Twp
- Frankton
- Franktown Twp
- Franktown Twp
- Frankville
- Frankship
- Free City Twp
- Frye Island
- Fryeburg
- Fr Fairfield
- Fr Kent Mills
- Gardiner
- Gardfield Pt
- Gardland
- Gardington
- Gilead
- Glen Cove
- Glenburn
- Glenwood Pt
- Glenham
- Glenholme
- Glen Isle
- Grand Lake Stream
- Grand Lk Stern
- Gray
- Great Diamond Island
- Great Pond
- Greenbush
- Greene
- Greenfield Twp
- Greenfield Twp
- Greenville
- Greenville Junction







- [illegible]



- [illegible]

- ☐ Wintlow
- ☐ Winter Harbor
- ☐ Wintropet
- ☐ Wintrop
- ☐ Wisconsin
- ☐ Woodland
- ☐ Woodville
- ☐ Woodville
- ☐ Wyngillock
- ☐ Yarmouth
- ☐ York
- ☐ York Beach
- ☐ York Harbor

1.4.19. Referral Provider NPI Number:

1.4.20. Indicate the referent's name, email address, and phone number:

If you answered "Section 45 Home and Community Based Treatment (HCT) Services" on question 1

1.5.1. Type of Section 45 HCT services

(Please select one.)

- ☐ HCT
- ☐ HCT-FFT
- ☐ HCT-MST
- ☐ HCT-PSB

1.5.2. Reason for referral (Please include symptoms and behaviors (frequency, intensity, and duration) that support the level of care requested):

1.5.3. Has the child been suspended or expelled from child care and/or an educational setting?

(Please select one.)

- ☐ Yes
- ☐ No

If you answered "Yes" on question 1.5.3

1.5.3.1.1. Provide the date:

1.5.4. Is the member's need for service primarily due to their Intellectual Disability/Developmental Disability diagnosis?

(Please select one.)

- ☐ Yes
- ☐ No

1.5.5. When is the family available to be served?

(Please select between 1 and 3 items.)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

1.5.6. Is member interested in telehealth?

(Please select one.)

- ☐ Yes
- ☐ No

If you answered "Yes" on question 1.5.6

1.5.6.1.1. Does member have technology to participate in telehealth?

(Please select one.)

- ☐ Yes
- ☐ No

1.5.6.1.2. Is the member open to telehealth for some of the service or all of the service?

(Please select one.)

- ☐ Some of the service
- ☐ All of the service

1.5.7. Is this request a result of remote learning?

(Please select one.)

- ☐ Yes
- ☐ No

If you answered "Yes" on question 1.5.7

1.5.7.1.1. Please explain

1.5.8. Does this member have a guardian?

(Please select one.)

- ☐ Yes
- ☐ No

If you answered "Yes" on question 1.5.8

1.5.8.1.1. List guardian name and phone number

1.5.9. Is the member receiving Outpatient Services?

(Please select one.)

- ☐ Yes
- ☐ No

If you answered "Yes" on question 1.5.9

1.5.9.1.1. Please describe why Outpatient level of care is not meeting members needs

If you answered "No" on question 1.5.9

1.5.9.2.1. Please describe why Home-Based Community Treatment (HCT) is needed versus lower level of care.

1.5.10. Has the member had HCT in the home within six (6) months?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.5.10

1.5.10.1.1. Please discuss why sustainable progress has not been made.

1.5.11. Has the child been involved in the Juvenile Justice System? (If yes, please provide dates)

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.5.11

1.5.11.1.1. Please Explain:

1.5.12. Have you explored Multi Systemic Therapy (MST) or Functional Family Therapy (FFT) services?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.5.12

1.5.12.1.1. Which service was explored?

1.5.12.1.2. When did you refer the member to this service?

If you answered "No" on question 1.5.12

1.5.12.2.1. Why was the member not referred to these services?

1.5.13. Is the youth at risk for out of home treatment or transitioning home from out of home treatment?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.5.13

1.5.13.1.1. Please Explain:

1.5.14. Would the child/family be willing to receive HCT via a clinician only model?

(Please select one.)

- ☐ Yes  
☐ No

1.5.15. Does the family have a preferred provider?

(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.5.15

1.5.15.1.1. Select the Specialized Section 28 Preferred Provider

(Please select one.)

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> ABC Behave                           | <input type="checkbox"/> Best Divini & Associates                            | <input type="checkbox"/> CARD- Center for Autism & Related Disorders | <input type="checkbox"/> CASA, Inc.                             | <input type="checkbox"/> Compass Behavioral Health |
| <input type="checkbox"/> Connections for Kids                 | <input type="checkbox"/> COR Health Services                                 | <input type="checkbox"/> Counseling and Trauma Therapy Associates    | <input type="checkbox"/> Discovering Kids Consultation Services | <input type="checkbox"/> Downstate Horizons, Inc.  |
| <input type="checkbox"/> Eastern Maine Counseling and Testing | <input type="checkbox"/> E.C.C.O., LLC                                       | <input type="checkbox"/> Innovations Behavior Services               | <input type="checkbox"/> Mark R. Hammond, Inc.                  | <input type="checkbox"/> Pathways                  |
| <input type="checkbox"/> R.I.S.E., INC                        | <input type="checkbox"/> Soquel Care   | <input type="checkbox"/> Sunrise Opportunities                       | <input type="checkbox"/> Woodlands                              | <input type="checkbox"/> The Northern Lighthouse   |
| <input type="checkbox"/> UCP of Maine                         | <input type="checkbox"/> Woodlands (all counties except Cumberland and York) |  |   |  |

1.5.15.1.2. Select the Non-Specialized Section 28 Preferred Provider:

(Please select one.)

- |   |  |  |  |   |  |  |  |   |   |   |   |  |
|---|--|--|--|---|--|--|--|---|---|---|---|--|
| <input type="checkbox"/> 10 Forward Programs for Families and Communities | <input type="checkbox"/> ABC Behave, LLC | <input type="checkbox"/> Adam Healthcare Services, LLC | <input type="checkbox"/> Addison Pointe Specialized Services, Inc. | <input type="checkbox"/> Affinity                 | <input type="checkbox"/> Ancestry Home Health Services | <input type="checkbox"/> Aprio Behavioral Health & Counseling- Home Hope & Healing | <input type="checkbox"/> Back To Basics Behavioral Health Services, Inc. | <input type="checkbox"/> Bangor Counseling Center | <input type="checkbox"/> Behavioral Health Solutions for ME | <input type="checkbox"/> Black Bear Support Services, LLC | <input type="checkbox"/> Best Divini & Associates | <input type="checkbox"/> Bridges of Maine, LLC |
| <input type="checkbox"/> Bright Futures                                   | <input type="checkbox"/> Care & Connect  | <input type="checkbox"/> Catcha                        | <input type="checkbox"/> Central Ancestry                          | <input type="checkbox"/> Choices Are for Everyone | <input type="checkbox"/> Christie Place Assn.          | <input type="checkbox"/> CASA, Inc.  | <input type="checkbox"/> Compass Behavioral                              | <input type="checkbox"/> Connections              | <input type="checkbox"/> Community                          | <input type="checkbox"/> COR Health                       | <input type="checkbox"/> Discovering Kids         | <input type="checkbox"/> Counseling and Trauma |





- ☐ Biddeford  
☐ Biddeford Pt  
☐ Biddeford Pool  
☐ Big Lake Twp  
☐ Bingham  
☐ Birch Harbor  
☐ Birch Island  
☐ Blaine  
☐ Blanchard Twp  
☐ Blue Hill  
☐ Boctusay  
☐ Boctusay Harbor  
☐ Boctusay Nar  
☐ Bowdoin  
☐ Bowdoinham  
☐ Bowdoinham  
☐ Bradford  
☐ Bradley  
☐ Bremen  
☐ Brewer  
☐ Bridgewater  
☐ Bridgton  
☐ Brighton Pt  
☐ Bristol  
☐ Brookline  
☐ Brooks  
☐ Brooksville  
☐ Brookton  
☐ Brownfield  
☐ Brownville  
☐ Brownville Junction  
☐ Brownville Jct  
☐ Brunswick  
☐ Bryant Pond  
☐ Buckfield  
☐ Bucks Harbor  
☐ Bucksgate  
☐ Burlington  
☐ Burnham  
☐ Business Is  
☐ Business Island  
☐ Buxton  
☐ Byron  
☐ Cactus  
☐ Cambridge  
☐ Camden  
☐ Cannon  
☐ Canton  
☐ Cape Cottage  
☐ Cape Elm  
☐ Cape Elizabeth  
☐ Cape Noddy  
☐ Cape Porpoise  
☐ Capitol Is  
☐ Capital Island  
☐ Carabasset Vly  
☐ Carleton  
☐ Cardville  
☐ Caribou  
☐ Carmel  
☐ Carabasset Valley  
☐ Carrs Pt  
☐ Carrying Place Town Twp  
☐ Carthage  
☐ Cary Pt  
☐ Carving Pt Twp  
☐ Casco  
☐ Castine  
☐ Castle Hill  
☐ Carroll  
☐ Cashesua Twp  
☐ Center Level  
☐ Centerville  
☐ Chain Of Ponds  
☐ Chain Of Ponds Twp  
☐ Chamberlain  
☐ Chapman  
☐ Charlston  
☐ Chatham  
☐ Chatham  
☐ Chebogue Is  
☐ Chebogue Island  
☐ Chelsea  
☐ Cherryfield  
☐ Chester  
☐ Chesterville  
☐ China  
☐ China Village  
☐ China Vly  
☐ Clayton Lake  
☐ Cliff Island  
☐ Clifton  
☐ Clinton  
☐ Colburn Grove  
☐ Colbyville Pt  
☐ Colburns  
☐ Colburns Falls  
☐ Colburns Fk  
☐ Concord Twp

- [illegible]

- [illegible]

- ☐ Acton
- ☐ Andover
- ☐ Andover
- ☐ Ayer
- ☐ Bedford
- ☐ Bear Not Top
- ☐ Johnson Mountain Top
- ☐ Amesbury
- ☐ Amherst
- ☐ Andoverport
- ☐ Ames Mill
- ☐ Ames Falls
- ☐ Kingsfield
- ☐ Kingman
- ☐ Kingman Top
- ☐ Kittery
- ☐ Kittery Point
- ☐ Keen
- ☐ L.L. Bean Co.
- ☐ Lagrange
- ☐ Lake View Pl.
- ☐ Lakeside
- ☐ Lambert Lake
- ☐ Lanesville
- ☐ Lang Top
- ☐ Lebanon
- ☐ Lee
- ☐ Leeds
- ☐ Levant
- ☐ Lewiston
- ☐ Lewington Top
- ☐ Liberty
- ☐ Lily Bay Top
- ☐ Lincolnton
- ☐ Livestone
- ☐ Livingston
- ☐ Lincoln
- ☐ Lincoln Center
- ☐ Lincoln Ctr.
- ☐ Lincolnville
- ☐ Lincolnville Center
- ☐ Lincoln Cr.
- ☐ Linnaea
- ☐ Lisbon
- ☐ Littleton Falls
- ☐ Littleton
- ☐ Little Deer Isle
- ☐ Little Diamond Island
- ☐ Littleton
- ☐ Livermore
- ☐ Livermore Falls
- ☐ Livermore Fl.
- ☐ Long Island
- ☐ Long Pond Top
- ☐ Longmire Cr. Cn.
- ☐ Lowell
- ☐ Lowell
- ☐ Mt. Dear Is.
- ☐ Mt. Dear Is.
- ☐ Lubec
- ☐ Ludlow
- ☐ Lyman
- ☐ Mac Mahan
- ☐ Machias
- ☐ Machiasport
- ☐ Machiassee Pt.
- ☐ Madawaska
- ☐ Madison
- ☐ Madrid Top
- ☐ Manchester
- ☐ Manchester Pt.
- ☐ Magnolia
- ☐ Mainville
- ☐ Maine Top
- ☐ Mars Hill
- ☐ Marshfield
- ☐ Masada
- ☐ Mason Top
- ☐ Mattamuskeet
- ☐ Mattamuskeet Top
- ☐ Mattaville
- ☐ Mayfield
- ☐ Mayfield Top
- ☐ Mechanic Falls
- ☐ Mechanic Fl.
- ☐ Medford Springs
- ☐ Medford
- ☐ Medway
- ☐ Merce
- ☐ Merce Point
- ☐ Merrill
- ☐ Meserve
- ☐ Metchie
- ☐ Milford
- ☐ Milbrook
- ☐ Mile

- ☐ Milton Top
- ☐ Minot
- ☐ Minam
- ☐ Molokini Top
- ☐ Monhegan
- ☐ Monroe wh
- ☐ Monro
- ☐ Monro n
- ☐ Monticello
- ☐ Montville
- ☐ Moody
- ☐ Moore River
- ☐ Moss Pt
- ☐ Mossil
- ☐ Moosew
- ☐ Mount Chase
- ☐ Mount Desert
- ☐ Mount Vernon
- ☐ Mount Gers
- ☐ Mount Gers Top
- ☐ N Bridge
- ☐ N Fryburg
- ☐ N Monroe wh
- ☐ N New Portland
- ☐ N New Portland
- ☐ N Stoughton
- ☐ N Sullivan
- ☐ N Vauxboro
- ☐ N Waterboro
- ☐ N Waterford
- ☐ N Yarmouth
- ☐ Naples
- ☐ Nashville Pit
- ☐ New Canada
- ☐ New Gloucester
- ☐ New Gloucester
- ☐ New Harbor
- ☐ New Limerick
- ☐ New Portland
- ☐ New Sharon
- ☐ New Sweden
- ☐ New Vineyard
- ☐ Newagen
- ☐ Newburgh
- ☐ Newcastle
- ☐ Newfield
- ☐ Newport
- ☐ Newry
- ☐ Noblesboro
- ☐ North Andover
- ☐ North Brunswick
- ☐ North Bridge
- ☐ North Fryburg
- ☐ North Haven
- ☐ North Jay
- ☐ North Monroe wh
- ☐ North New Portland
- ☐ North Stoughton
- ☐ North Sullivan
- ☐ North Turner
- ☐ North Vauxboro
- ☐ North Waterboro
- ☐ North Waterford
- ☐ North Yarmouth
- ☐ Northeast Harbor
- ☐ Northeast Mt
- ☐ Northfield
- ☐ Northport
- ☐ Norway
- ☐ Oakfield
- ☐ Oakland
- ☐ Ocean Park
- ☐ Ogunquit
- ☐ Okemos
- ☐ Old Orchard Beach
- ☐ Old Orchard Bch
- ☐ Old Town
- ☐ Oquossoc
- ☐ Orient
- ☐ Orland
- ☐ Orville Top
- ☐ Orono
- ☐ Orrington
- ☐ Orrs Island
- ☐ Oxbow
- ☐ Otis
- ☐ Otisfield
- ☐ Otter Creek
- ☐ Otis Island
- ☐ Oxbow
- ☐ Oxbow
- ☐ Palamere
- ☐ Palmyra
- ☐ Paris
- ☐ Parkman
- ☐ Paris Pt Top
- ☐ Paris Pt Top

- [illegible]

- [illegible]

- ☐ Waldie
- ☐ Waldoboro
- ☐ Walden
- ☐ Walgreens
- ☐ Walpole
- ☐ Walkham
- ☐ Warren
- ☐ Washburn
- ☐ Washington
- ☐ Waterboro
- ☐ Waterford
- ☐ Waterville
- ☐ Wayne
- ☐ Webster Pk
- ☐ Weeks Mills
- ☐ Weld
- ☐ Wellington
- ☐ Wells
- ☐ Wellesley
- ☐ West Baldwin
- ☐ West Bath
- ☐ West Bethel
- ☐ West Boothby Harbor
- ☐ West Enfield
- ☐ West Farrington
- ☐ West Fenton
- ☐ West Gardiner
- ☐ West Kennelbuck
- ☐ West Minor
- ☐ West Newfield
- ☐ West Paris
- ☐ West Poland
- ☐ West Rockport
- ☐ West Scarborough
- ☐ West Tremont
- ☐ Westbrook
- ☐ Winfield
- ☐ Winthrop
- ☐ Winthrop Island
- ☐ Winthrop Island
- ☐ Whitefield
- ☐ Whiting
- ☐ Whitneyville
- ☐ Williamsburg Twp
- ☐ Williamsburg Twp
- ☐ Wilton
- ☐ Wilton
- ☐ Windham
- ☐ Windsor
- ☐ Wins
- ☐ Winslow
- ☐ Winter Harbor
- ☐ Wintrop
- ☐ Wintrop
- ☐ Wiscasset
- ☐ Woodland
- ☐ Woodville
- ☐ Woolwich
- ☐ Wytopitlock
- ☐ Yarmouth
- ☐ York
- ☐ York Beach
- ☐ York Harbor

1.5.19. ReferralProvider.NPINumber

1.5.20. Indicate the referent's name, email address, and phone number.

1.5.21. **KEPRO INTERNAL USE ONLY**  
(Please select one.)  
☐ PCIT

If you answered "Section 65 Medication Management" on question 1

### 1.6.1. Client's Address

### 1.6.2. Client's Phone Number

### 1.6.3. Referent name, phone number, and email address

#### 1.6.4. Service Referring for

#### 1.6.5. Agency Referring to



1.6.6. Reason for referral

If you answered "Section 92 Behavioral Health Home (BHH) Services" on question 1

1.7.1. Indicate the referent's name, email address, and phone number

If you answered "Section 97 Children's Residential Care Facilities (CRCF)" on question 1

1.9.1. For all youth it is required that consultation be obtained from CBHS before the CRCF application is submitted. Please check Yes if this conversation has occurred and then enter date and name of party consulted (Please select one.)

☐ Yes

If you answered "Yes" on question 1.9.1

1.9.1.2.1. Please enter date

1.9.1.2.2. Please enter time

1.9.1.2.3. Please enter name of party consulted

1.9.2. For youth in DHS custody it is required that consultation be obtained from CBHS before the CRCF application is submitted. Please check Yes if this conversation has occurred and then enter date and name of party consulted (Please select one.)

☐ Yes

If you answered "Yes" on question 1.9.2

1.9.2.2.1. Please enter date

1.9.2.2.2. Please enter time

1.9.2.2.3. Please enter name of party consulted

1.9.3. Indicate the referent's name, email address, and phone number:

1.9.4. Indicate the team member(s) who will be attending face to face assessment. Please provide name, email address, and phone number

1.9.5. Current location (Please select one.)

- ☐ Crisis Unit ☐ Home/Foster Home  
☐ Hospital ☐ Mountain View/Long Creek  
☐ Residential Treatment Program ☐ Shelter  
☐ Other:

If you answered "Other" on question 1.9.5

1.9.5.7.1. Explain other:

1.9.6. Has there been a CAFAS, GAF, or CHAT completed within the past ten (10) days? (Please select one.)

☐ Yes  
☐ No

If you answered "Yes" on question 1.9.6

1.9.6.1.1. Please list the title and date of document(s) that support this criteria.

1.9.7. Does the child demonstrate a current need for Therapeutic Treatment or availability of a Therapeutic On-Site Response on a 24 hour basis? (Please select one.)

☐ Yes  
☐ No

If you answered "Yes" on question 1.9.7

1.9.7.1.1. Please list the title and date of document(s) that support this criteria.

1.9.8. Even with intensive community intervention, including services and supports, there is significant potential that the child would be hospitalized or there is a clear indication that the child's condition would significantly deteriorate and would require a higher level of service than can be provided in the home and community. (Please select one.)

☐ Yes  
☐ No

If you answered "Yes" on question 1.9.8

1.9.8.1.1. Please list the title and date of document(s) that support this criteria:

1.9.9. Has the child displayed significant recent aggression (within the past two (2) months) across multiple environments or severe enough within one environment to have caused serious injury or there is significant potential of serious injury to self or others?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.9

1.9.9.1.1. Please list the title and date of document(s) that support this criteria:

1.9.10. Has the child demonstrated recent (within the past two(2) months) HOMICIDAL IDEATION (including intent, plan and means) with risk to harm to self or others?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.10

1.9.10.1.1. Please list the title and date of document(s) that support this criteria:

1.9.11. Has the child demonstrated recent (within the past two(2) months) SUICIDAL IDEATION (including intent, plan and means) with risk to harm to self or others?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.11

1.9.11.1.1. Please list the title and date of document(s) that support this criteria:

1.9.12. Has the child demonstrated symptoms of mental illness, mental retardation, or pervasive developmental disorders (within the past (2) months) that have resulted in the inability to care for self to a developmentally appropriate level, even with home and community supports?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.12

1.9.12.1.1. Please list the title and date of document(s) that support this criteria:

1.9.13. Has the child not responded to a less restrictive level of care OR would have a significant risk of harm to self or others if a less restrictive setting were attempted?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.13

1.9.13.1.1. Please list the title and date of document(s) that support this criteria:

1.9.14. Indicate the referent's name, email address, and phone number:

Instructions: Demographics

1.9.15. Was it in Child Welfare Custody?

(Please select one.)

- ☐ Yes  
☐ No

1.9.16. Is DOC involved?

(Please select one.)

- ☐ Yes  
☐ No

1.9.17. District

Instructions: Legal Guardian Name/ Address

1.9.18. Name

1.9.19. Address (Number and Street)

1.9.20. ZIP

Min/Max - 000000; No decimal places allowed

1.9.21. Phone

1.9.22. Fax

1.9.23. Email Address

1.9.24. For all youth it is required that consultation be obtained from CBSE before the CRCF application is submitted. Please check Yes if this conversation has occurred and then enter date and name of party consulted (Please select one.)

☐ Yes

If you answered "Yes" on question 1.9.24

1.9.24.2.1. Please enter date

1.9.24.2.2. Please enter time

1.9.24.2.3. Please enter name of party consulted

Instructions: Care Manager

1.9.25. Name

1.9.26. Agency

1.9.27. Address (Number and Street)

1.9.28. ZIP  
Min/Max - 000000; No decimal places allowed

1.9.29. Phone

1.9.30. Email Address

1.9.31. Fax

1.9.32. Supervisor Name

1.9.33. Email Address

1.9.34. Phone

1.9.35. Current location  
(Please select one.)

- ☐ Crisis Unit ☐ Home/Foster Home  
☐ Hospital ☐ Mountain View/Long Creek  
☐ Residential Treatment Program ☐ Shelter  
☐ Other:

If you answered "Other" on question 1.9.35

1.9.35.1. Explain other:

Instructions: NOTE: Care manager does not have to complete the rest of the questionnaire if this is a request for transfer CRCF REQUEST FOR TRANSFER CRCF Obtain clinical letter from current RNMI Clinician. The letter must include the following: 1. Youth's current diagnosis and GAF 2. A description of recent behaviors and symptoms that have required the need for alternative treatment. Please provide an explanation of why the youth can no longer be served by the agency 3. Current specific treatment recommendations for the youth and family

1.9.36. Is this a transfer CRCF Request?  
(Please select one.)

- ☐ Yes  
☐ No

1.9.37. Most Recent School Attended

1.9.38. Does the youth have an IEP?  
(Please select one.)

- ☐ Yes  
☐ No

1.9.39. Does the youth have a 504 Plan?  
(Please select one.)

- ☐ Yes  
☐ No

- ☐ Yes  
☐ No

1.9.40. Is the child presently taking medications to address Mental Health Impairment?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.40

1.9.40.1.1. Ensure all psych meds are listed in submission

If you answered "No" on question 1.9.40

1.9.40.2.1. Please provide documentation explaining reason child does not receive medication or if not indicated

1.9.41. Diagnoses given within the past 6 months  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.41

1.9.41.1.1. Please list the title and date of document(s) that support this criteria

1.9.42. Full Scale IQ (Required for Youth With Intellectual Disabilities)  
Min/Max - 0/170; No decimal places allowed

1.9.43. Date Given

1.9.44. Provider

Instructions: Please note this is required for eligibility. Entire scoring tool must be submitted for CAFAS/CHAT. Written justification must be submitted for GAF

1.9.45. CAFAS, GAF, CHAT within the past 10 days?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.45

Instructions: Please note this is required for eligibility. Entire scoring tool must be submitted for CAFAS/CHAT. Written justification must be submitted for GAF

1.9.45.1.1. Please enter CAFAS, CHAT or GAF score  
Min/Max - 0/9999999; No decimal places allowed

1.9.46. Did any of the child's behavioral health services close abruptly or prior to treatment goals being completed recently?  
(Please select one.)

- ☐ Yes  
☐ No

If you answered "Yes" on question 1.9.46

1.9.46.1.1. Please list the service and explain

1.9.47. Please identify if any of the following services are currently provided and/or have been in the past 12 months  
(Please select between 0 and 3 items.)

- ☐ MH Intensive Outpatient. Any behavioral health service under a hospital or organization (med management or OP)  
☐ Foster Care A and B  
☐ Any Services Not Funded By Maine Care

Instructions: MH Intensive Outpatient (IOP). Any behavioral health service under a hospital or organization (med management or OP)

1.9.48. Start

1.9.49. End

1.9.50. INDIVIDUAL PROVIDER AND AGENCY AFFILIATION List provider agency along with name of individual providing service

1.9.51. Frequency

Instructions: Foster Care A and B

1.9.52. Start

1.9.53. End

1.9.54. INDIVIDUAL PROVIDER AND AGENCY AFFILIATION List provider agency along with name of individual providing service

1.9.55. Frequency

Instructions: Any Services Not Funded By Maine Care

1.9.56. Start

1.9.57. End

1.9.58. **INDIVIDUAL PROVIDER AND AGENCY AFFILIATION** List provider agency along with name of individual providing service

1.9.59. Frequency

Instructions: <https://www.maine.gov/dhs/sites/maine.gov/dhs/files/documents/ocf/dhs/provider/documents/section9%20consultguide.pdf>

1.9.60. Have you reviewed *Residential Consult Guide with Family and Youth*?

(Please select one.)

- ☐ Yes  
☐ No

Instructions: To see the document please copy and paste the following address into your web browser: <https://www.maine.gov/dhs/sites/maine.gov/dhs/files/documents/ocf/dhs/provider/documents/TIR%20brochure%2010.21.2020.pdf>

1.9.61. Have you reviewed *CRCF Brochure with Family and Youth*?

(Please select one.)

- ☐ Yes  
☐ No

Instructions: For all youth it is required that consultation be obtained from CBHS before the CRCF application is submitted. To see the document please copy and paste the following address into your web browser:

<https://www.maine.gov/dhs/ocf-support-for-families/childrens-behavioral-health/services/residential-treatment>

1.9.62. Has the *Educational Planning and Notification for CRCF with Guardian* been reviewed?

(Please select one.)

- ☐ Yes  
☐ No

1.9.63. Is the *Diagnostic List* provided by the most current licensed mental health provider within last 6 months?

(Please select one.)

- ☐ Yes  
☐ No

1.9.64. Have you included *Treatment progress notes* from ALL mental health providers from the past 2 months?

(Please select one.)

- ☐ Yes  
☐ No

1.9.65. Have you included *Mood Crisis assessments* from the past 2 months?

(Please select one.)

- ☐ Yes  
☐ No

1.9.66. Have you provided *Admission and Discharge summaries* from ALL mental health treatment providers over the past 12 months?

(Please select one.)

- ☐ Yes  
☐ No

1.9.67. Have you included *Physician or PCP letter*?

(Please select one.)

- ☐ Yes  
☐ No

1.9.68. Have you included *incident reports* from the past 2 months?

(Please select one.)

- ☐ Yes  
☐ No

1.9.69. Have you included the most recent *psychological, psychiatric or neuropsychological evaluation*?

(Please select one.)

- ☐ Yes  
☐ No

Instructions: It is the responsibility of the guardian to notify the following funding sources when a child enters or leaves CRCF: Financial Resources, Social Security Income, Adoption Subsidy, Maine Care and/or Private Insurance. Other funding sources (Parental death benefits, trust funds, etc.) It is the responsibility of the case manager to notify the Sending School or SALJ and DOE any time a youth is being admitted to a residential facility. SAC.DOE@maine.gov If you are unsure who the sending school is, contact DOE at SAC.DOE@maine.gov

1.9.70. Have you completed *required notifications* any time a youth is placed in Residential treatment?

(Please select one.)

- ☐ Yes  
☐ No

Instructions: Education planning is a vital part of the process when children must be placed outside of their home. School must be included in the discussion when there is consideration of applying for residential treatment. Their ability to serve a child can be impacted when the child is located out of their district. Appropriate school staff must be included in conversations about any potential out of home placements. School teams are very creative when developing individualized education opportunities, and they often have many options to consider. When youth are being considered for treatment in an out of home setting, additional planning is required. Formal notification that admission will occur must be provided to the school as soon as an admission date is available. 1) Include current school in conversations about the potential need for residential treatment. 2) Will notify parent school if CRCF is approved.

1.9.71. Have you completed *required action steps* to ensure appropriate educational planning while out of home?

(Please select one.)

- ☐ Yes  
☐ No

1.9.72. Have you included the information if the youth is currently in a corrections facility?

(Please select one.)

- ☐ Yes  
☐ No

Instructions: If you have access to Access complete the request at (please copy and paste the following address into your web browser): <http://www.qualitycareforme.com/services/Intensive-Temporary-Residential-treatment/> If you don't have access to Access provide the clinical letter to Kyrus via secure email at [lettersME@kyrus.com](mailto:lettersME@kyrus.com) Call Kyrus to confirm receipt of the letter 1-866-821-0184.

1.9.73. Is this a *Request for Transfer CRCF*?

(Please select one.)

- ☐ Yes  
☐ No