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| **Referral**MaineCare Section 28Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (RCS) |

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| **This Request is for:**  |
| [ ]  | Specialized Section 28 – Community |
| [ ]  | Non-Specialized Section 28 - Community |
|  |  |
| [ ]  | Specialized Section 28 – School-Based |
| [ ]  | Non-Specialized Section 28 – School-Based |

Referral must include:

**[ ]  Signed Authorization to Release Information Form**

**[ ]  Diagnostic Information** (page 2)

[ ]  **Physician’s Letter of Eligibility** (Birth-5)

[ ]  **Functional Assessment Scores, date** (page 2)

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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: |  |  |
|  |
| **Information about Child:** Child’s Name (spelled 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: |       |
|  |
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| **Legal Guardian(s)** Name & mailing address |
|       |
|       |
|       |
| Phone #:  |       | Cell:  |       |
| **Shared Custody** Name & mailing address |
|       |
|       |
|       |
| Phone #:  |       | Cell:  |       |

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| **Guardian(s) Custody** |
| Married | [ ]  Yes |
| Sole | [ ]  Yes |
| Shared | [ ]  Yes |
| Name/Address under Shared Custody |
| DHHS | [ ]  Yes |
| Own | [ ]  Yes |

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|  |  |
| **Diagnosis: (DSM) & Code** | **Date:**  | **Functional Assessment Date:**  |
|  |  |  |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **Code:**  | Composite/GAC Score: |       |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **Code:** | Subscale Scores  |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **Code:** | (Required when composite score is < 2 s.d.) |
| **Diagnosis: (DC 0-3) & Code:** | **Date:**  | Communications/Conceptual: |       |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **Code:** | Social: |       |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **Code:** | Assessment Tool Used: |       |  |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **Code:** |  |  |
| **Diagnosis provided by:**  | **Assessment Completed by:** |
| **Name:** | **Name:** |
| **Credentials:** | **Credentials:** |
| Description of Identified Need: (please attach additional sheets as needed)      |
|  |
| Questionnaire Information: |
| 1. Has the child been suspended or expelled from childcare and/or an educational setting?
 | [ ]  Yes | Expulsion/Suspension Date:       | [ ]  No |
| 1. Is the member’s current need for service primarily due to their Intellectual Disability/Developmental Delay Diagnosis
 | [ ]  Yes | [ ]  No |  |
| 1. When is the family available to be served?
 | [ ]  Morning | [ ]  Afternoon | [ ]  Evening  |
| 1. Will the child receive services at the address specified on this referral?
 | [ ]  Yes | [ ]  No | Specify Address (including town)      |
| 1. Is this request a result of remote learning?
 | [ ]  Yes | [ ]  No | If yes, please explain:       |
| 1. Has the child been involved in the Juvenile Justice System?
 | [ ]  Yes | [ ]  No | If yes, please explain and provide dates:       |
| 1. Have you explored Multi-Systemic Therapy (MST) or Functional Family Therapy (FFT)?
 | [ ]  Yes (Please explain which service was explored and dates member was referred to those services) | [ ]  No (Please explain why member was not referred to these services) | Please explain:       |
| 1. Is the member interested in telehealth?
 | [ ]  Yes | [ ]  No |  |
| 1. Does member have technology to participate in telehealth?
 | [ ]  Yes | [ ]  No |  |
| 1. Is member open to telehealth for some of the service or all of the service?
 | [ ]  Some of the service | [ ]  All of the service |  |
| **Family Preference**You may identify one Preferred Provider, but this provider may not be the first available to being 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