



# ANGLEZ

*Behavioral Health Services*

**844-294-5306**

www.anglezbhs.com

841 Riverside Dr. Augusta, ME 04330

Fax: 1-844-294-5306

Psychiatry:  MH OPT  COMP ASSESS **Referral Form**

Referral Date:

Adult:  CM  DLS  SKILLS

Children:  Child 's CM  HCT Required: Complete SECT 65 HCT referral packet Attached

**Interpreter Services needed:**  Yes  No

ARE YOU RECEIVING ANY SERVICES FROM ANOTHER AGENCY? IF YES, WHO: \_\_\_\_\_

Individual Requesting Services:

Phone Number:

Relation to Applicant:

Name of person completing this form:

**Demographics (Name as it appears on Insurance card)**

First:	Last:	M:
<b>DOB</b>	SSN:	Gender:
Race (optional):	Medicare#:	MC#
	Primary Ins Group#:	Primary Ins Group#:

**Current Residence:**

Street:			
Town:	State:	Zip:	Phone:

**DSM—IV Primary Diagnosis, LOCUS, and GAF**

AXIS 1 (ICD-10)	LOCUS:	GAF:
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Must have a DX of Schizophrenia or Schizoaffective Disorder to be eligible for section 17 services

OR

Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:

\_\_\_\_\_ a) documented history, stating that he/she is likely to have: future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support services are provided; based on need: rental history; or

\_\_\_\_\_ b) has received treatment in state psychiatric hospital, within the past 24 months.; or has a non-excluded DSM-IV 5 diagnosis; or

\_\_\_\_\_ c) has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or

\_\_\_\_\_ d) has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months, for a non- excluded DSM 5 diagnosis: or

\_\_\_\_\_ e) has been committed by a civil court for psychiatric treatment as an adult;

\_\_\_\_\_ f) until the age of 21, the recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a clinician, in the last 12 months, stating that the recipient had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided

Parent/Guardian Information

**Own Guardian (Age 18+)**  **Parents Married & Living Together**  **Shared Custody (both must sign paperwork)**

**Sole Custody (Copy of Custody Agreement or PFA)**

Parent/Guardian	<input type="checkbox"/> Residency
Address:	Phone
Parent/ Guardian	<input type="checkbox"/> Residency
Address:	Phone:

Copy of Diagnosis Attached