MaineGeneral Community Care

Behavioral Health Services

ACT Intake Form

(Please fax or email completed form to the ACT Team)

Fax: (207) 621-3702

Email: actteamreferrals@mainegeneral.org

Date of Referral: _____ **Referring Provider:** _____

Referring Mailing Address: _____

Phone Number: _____ **Fax Number:** _____

Referral Source: Please describe the nature of the referral and why you feel this level of care is needed.

Client Name:

Last_____First_____Middle_____Maiden_____

Date of Birth: _____ **Social Security Number:** _____ - _____- _____

Mailing Address: **County** _____

City/Town _____ State_____ Postal Code _____

Physical Address, if different from mailing address:

City/Town _____ State _____ Postal Code _____

Primary Phone Number: _____ **Secondary Phone Number:** _____

Class Member: Yes☐ No☐

Have you ever received services here before: Yes☐ No☐

Living Arrangements:

Unhoused ☐ Alone ☐ Lives with family ☐ Homeless shelter ☐ PNMI ☐

Other (please specify) _____

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Sex at Birth:

Male ☐ Female ☐ Other ☐

Identified Gender: Male ☐ Female ☐ Other ☐

Sexual Orientation:

Heterosexual ☐ Bisexual ☐ Asexual ☐ Homosexual ☐ Other ☐

Marital Status:

Single ☐ Married ☐ Divorced ☐ Separated, legally ☐ Widowed ☐ Life Partner ☐ Civil Union ☐ Unknown ☐

Ethnicity:

Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Patient declined to answer ☐ Patient not present ☐

Race:

White ☐ Black ☐ Native or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐

American Indian ☐ Some mixture of two or more of these groups ☐ Other ☐

Guardian Name/Mailing Address (if, applicable): _____

City/Town _____ State _____ Postal Code _____

(*Please attach guardianship paperwork for records*) Yes☐ No☐

(if, No please explain) _____

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Emergency Contact:

Name: _____ Relationship to Client: _____

Mailing Address: (Physical Address, if different from mailing address)

City/Town _____ State _____ Postal Code _____

Primary Phone Number: _____ Secondary Phone Number: _____

Pregnant: Yes☐ No☐ (if, Pregnant): IV Drug User? Yes☐ No☐ **OR** Substance Use Disorder? Yes☐ No☐

Open Case with DHHS Office of Child and Family Services? Yes☐ No☐ (if yes, please specify below)

_____

Primary Care Provider/Practice Name/Address: _____

Phone Number: _____ Fax Number: _____

Allergies (Medication/Food/Latex)? Yes☐ No☐ (if yes, please attach a list)

Special Accommodations Required? Yes☐ No☐ Handicap ☐ Interpreter ☐
Other (please specify) _____

DSM V Diagnostic Codes and Title: (Please attach most recent evaluation/assessment)

Current Medications: (Please attach most recent medication sheet)

Current Medical Status/Conditions: (please specify below)

_____

Insurance Information:

No INS ☐ Self Pay ☐ MaineCare ☐ Medicare ☐ Commercial ☐
Other, specify_____

Subscriber: _____ Guarantor: _____

Policy Number: _____Group Number: _____

Provide copy of Insurance Card? Yes/No (if No, please explain) _____

AS0950

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Number in Household: _____

Household Income: $_____ **Declined to give Household Income** ☐

Hospitalizations:

Hospital Name and Dates _____

Incarcerations:

Facility Name and Dates _____

Current Legal Issues? Y ☐ N ☐ _____

Probation/Pretrial/Drug Court

***********THIS SECTION IS FOR MGCC BHS ADMINISTRATIVE STAFF USE ONLY***********

ACT Admission Date (Tier): _____

Date Reviewed with Clinical Team: _____

Disposition:

Meets Criteria ☐ Meets Criteria, add to waitlist ☐ Does Not Meet Criteria ☐