



COMMUNITY CONNECTIONS

A STATEWIDE RECREATIONAL LINKAGE SERVICE

150 Union St. Bangor, ME 04401 Out Area: 1-800-834-7150

Website: www.mmhc.us

Office 941-2998

Fax- 941-2996

APPLICATION FOR SERVICES

NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: ME ZIP: _____

COUNTY _____ TELEPHONE: _____ DATE OF BIRTH: _____

RELEASE OF INFORMATION

I authorize the Mental Health Service Provider named below to release the information requested below to be used for verification of eligibility for Community Connections, a program providing recreation linkage services to Mental Health Consumers. This information may be available to Community Connections, a program of Maine Mental Health Connections, Inc. I further authorize the Mental Health Service Provider named below to release information pertaining to membership in Community Connections including information and materials regarding usage of program facilities and appropriateness of usage of the program. I have had explained to me the risks and benefits of releasing the requested information and understand that I may revoke my consent at any time.

This release will expire one year from today.

Signature of Client or Guardian _____ Date _____

Person requesting information: Program Manager and staff of Community Connections

VERIFICATION BY MENTAL HEALTH SERVICE PROVIDER

*(Applicant: Please have your **Medical license** Provider complete this section Before Returning this Application to C.C.)*

The above named person is a recipient of Maine Mental Health Services. Persons who are receiving Services **Strictly** For Substance Abuse, Mental Retardation, Learning Disabilities, and Head Trauma are **Not** Eligible on their own. Please provide at least **One** other Mental Health diagnosis.

Medical Provider (Print Name)

Provider Title (Print)

Medical Provider Signature

Date

Name of Provider Health Care (Please Print)

Address of Providing Health Care (Please Print)

Diagnostic Criteria:

Principal Diagnosis: _____

This Section is Optional. Funding sources request collection of the following information. It is also useful to the program to better serve the participants. Your answers are confidential and will not affect your eligibility.

Age: _____ Sex: Male Female

Educational Background: Highest Level Completed: _____

Racial/Ethnic:

- White African-American Hispanic
 American Indian/Alaskan Native Asian/Pacific Islands Other

Marital Status:

- Never Married Married Remarried
 Separated Divorced Widowed

Income Level:

- Less than \$5,000 \$5,000 - \$6,999 \$7,000 - \$9,999
 \$10,000 - \$14,999 \$15,000 - \$19,999 \$20,000 - \$24,999
 \$25,000 - \$34,999 More than \$35,000

Living Arrangements:

- Alone With Other Boarding Home Supported Living
 Nursing Home Criminal Justice Crisis Arrangements Homeless
 Other Protective Living Arrangement

Referral Source:

- Friend Together Place Social Club Newspaper
 Clergy Mental Health Provider Physical Health Provider
 Criminal Justice Sector Inpatient Psychiatrist Residential Treatment Center
 State Mental Hospital Dep't. Human Services Poster/Flyer
 Substance Abuse Sector School
 Other (Please Specify) _____

Prior Treatment History:

- Inpatient Treatment Yes No
Community Mental Health Treatment Yes No
Prior Substance Abuse Treatment Yes No

Physical Disability:

- Deaf
 Learning
 None
 Other
 Mental Retardation/Developmentally Disabled
 Mobility Impaired
 Emotionally/Developmentally Delayed
 Blind