COMMUNITY CONNECTIONS

A STATEWIDE RECREATIONAL LINKAGE SERVICE
2 Second St., Bangor, ME 04401 OUT OF AREA: 1-800-834-7150
Office: 207-941-2998 Fax: 207-941-2996 Website: www.mmhc.us

APPLICATION
(PLEASE PRINT CLEARLY AND COMPLETE ALL FIELDS)

NAME: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ ST: ME ZIP: _____

COUNTY _____ TELEPHONE_____ DATE OF BIRTH: _____

RELEASE OF INFORMATION

I authorize the licensed mental health service professional named below to release the information requested 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 Maine Mental Health Connections staff, as MMHC administers Community Connections. I further authorize the licensed mental health service professional 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. The risks and benefits of releasing the requested information have been explained to me and I understand that I may revoke my consent at any time.

Signature of Applicant (or Guardian) _____ Date _____

VERIFICATION BY LICENSED MENTAL HEALTH SERVICE PROFESSIONAL

The following credentials are authorized to sign this application: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; physician, psychiatrist; psychiatric and mental health nurse practitioner (PMH-NP); psychiatric and mental health clinical nurse specialist (PMH-CNS); ANP; FNP; PA; or licensed psychologist.

The above applicant is a recipient of Mental Health Services in Maine. Persons who are receiving services **strictly** for substance use, mental retardation, learning disabilities, and head trauma are **not** eligible on their own. Please provide at least **one** other mental health diagnosis.

_____ _____
Licensed Mental Health Care Professional (Print) Title Ex: Therapist, etc. (Print)

_____ _____
Licensed Mental Health Care Professional (Signature) Date

_____
Agency Name and Address of Mental Health Care Provider (Print)

Principal Diagnosis: _____
(Codes are not needed)