R.A.M.P.

Restorative Approaches Maine Project

(Long-term, in-home family peer support)

Family Peer Specialist Support Referral Form

Date of Referral:

Parent(s) Name:

Address:

City/State/Zip:

Home/Cell Phone:

Email:

Children's Names/Ages:

Person making referral:

Phone:

Does family have TCM case management services?

☐ Yes ☐ No

Or enrolled in a BHH or CCBHC case management services?

☐ Yes ☐ No

If yes, include agency name here:

Is child/youth actively involved with children's behavioral health, child welfare, juvenile justice, and/or special education services? Please list which two below:

Primary child/youth in the home who has a mental health diagnosis.

☐ Yes, diagnosis is:

☐ No, will schedule or child is scheduled for a clinical evaluation to obtain diagnosis

☐ No diagnosis

Reason for referral and what supports does this family want or need?

Submit form by email

10 Caldwell Rd, Augusta, ME 04330 | 1-800-264-9224 | gearparentnetwork.org | dbouffard@kbhmaine.org