STATE OF MAINE
Department of
Health and Human Services

Self-Direction Pilot Referral Form

Please submit this form to kristin.m.thorp@maine.gov. Enrollment is based on eligibility and availability in Washington, Hancock, and Cumberland Counties. Please use the subject line: Self-Direction Pilot Referral, (County person lives). If you prefer to use an electronic form, the link can be found here.

If you need to send the form by mail, send to:

Kristin Thorp Quenson, DHHS/OBH
SHS 11,
41 Anthony Avenue
Augusta, ME 04333-0011

Participant Information		
Name:		**Date of Birth:**
Gender: ☐ Female ☐ Male ☐ Transgender, non-binary, or another gender ☐ Prefer not to say ☐ Other: _____	**Pronouns:** ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Zir/Zirs ☐ Other: _____	**Race/Ethnicity:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multiracial and/or Multiethnic ☐ Prefer not to say ☐ Other: _____
Address:		
Email:		**Primary Phone:**
Does the individual have any accessibility or accommodations needs (e.g. Interpreter, adaptive or assistive technology, etc.)? ☐ Yes ☐ No ☐ I am not sure		
Current Living Arrangement (Check all that apply): ☐ Alone ☐ With Spouse/Partner/Family ☐ With Non-Relative Roommate ☐ Paid Live-In Caretaker		☐ Caregiver/Guardian's Home ☐ Group Home/Residential Treatment Facility ☐ Psychiatric Institution/Facility
Does the individual have a guardian? ☐ Self ☐ Parent or Family Member: _____ ☐ Other: _____		

Is the individual currently receiving Section 17, Community Integration Services? ☐ Yes ☐ No	
If the individual receives Section 17, Community Integration Services, do they have an up-to-date and established Individual Service Plan? ☐ Yes ☐ No	
Referral Source if Other Than Self	
Name:	Agency:
Email:	Phone:
Who is the individual's Community Support Provider/Case Manager (if different from the referral source?)	
Is there anything else you would like for us to know?	