Maine ARC Request for Recovery Coach Services

Kennebec Behavioral Health

Please complete this entire form before submitting

Date of Request: _____

The following individual has requested a Recovery Coach:

Name: _____

Gender: _____

Race (check one): White _____ Black or African American _____ Asian_____

American Indian or Alaska Native_____ Native Hawaiian or Other Pacific Islander_____

More than one race_____ Other (specify: _____

Ethnicity (check one): Hispanic_____ Not Hispanic_____ Other (specify: _____

Date of birth (Month/Day/Year): _____

Phone: _____Text okay? (Yes/No) Okay to leave message? (Yes/No)

Other Phone:_____ Text okay? (Yes/No) Okay to leave message? (Yes/No)

Email: _____ Okay to email about events? (Yes/No)

Residence Street Address:* _____

Town, State, ZIP _____

***Check if currently without an address:** _____

Please deliver or FAX this request form to: (207)474-7794**

For more info contact:

Recovery Coach Coordinator

Name: Robin Cochrane-Crane

Phone: 207-474-8368 x 3621(Office) or 207-861-1410(Cell)

email: rcochrane-crane@kbhmaine.org

** Our program is HIPAA compliant we cannot receive Request Forms via email or text. Call if you need help getting your form to us.**

The mission of our Recovery Coach program is to provide the highest quality coaching experience for people seeking, or in recovery. We ask the following questions in order to:

Request for Recovery Coach Services

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1. To facilitate successful matching of coaches with participants.
2. To ensure the safety and well-being of all program participants.
3. For data collection purposes—we will not provide an evaluation of your history, or report on anyone's use of substances in a way that would identify you.

We appreciate your honest answers to the following questions.

What is your primary substance of use? _____

What is your secondary substance of use? _____

Approximate date of last substance use (Month/Day/Year)?

_____

Month Day Year

If the individual is referred by a partner organization:

Organization: _____

* Program setting: _____

Staff person completing form: _____

Staff Contact information: _____

[* Program Setting: Community, Corrections, Deferred Sentencing Program/Drug Court, Pre-Release Program, Emergency Department, Primary Care, Other (please specify)]

Check if self-referral _____

[For internal use only. Date Request Form Received: _____]