



## 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)612-3054

[For more info contact:](#)

#### Recovery Coach Coordinator

Name: Stacy Austin

Phone: 207-474-8368 x 3621(Office) or 207-861-1891(Cell)

email: saustin@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

**Please complete this entire form before submitting**

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: \_\_\_\_\_]*