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: _____ **Date of birth (month/day/year):** _____/_____/_____

Gender: _____

Ethnicity (check one): Hispanic☐ Not Hispanic☐ Other (specify): _____

Race (check one): White☐ Black or African American☐ Asian☐ American Indian or Alaska Native ☐Native Hawaiian or Pacific Islander☐ More than one race☐ Other (specify): _____

Residence street address: _____

Town, State, Zip: _____

☐ ***Check if currently without an address**

Phone: _____ **Is text okay? Yes☐ No☐ Is it okay to leave a message? Yes☐ No☐**

Other Phone: _____ **Is text okay? Yes☐ No☐ Is it okay to leave a message? Yes☐ No☐**

Email: _____ **Is it okay to email about events? Yes☐ No☐**

For more information contact:

Recovery Coach Coordinator
Name: Stacy Austin
Phone: (207) 474-8368 x3621 (office) or (207) 861-1891 (cell)
Email: SAustin@kbhmaine.org

Please deliver or fax this request form to: Kennebec Behavioral Health or (207) 612-3054
5 Commerce Ave
Skowhegan Maine

**** 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:

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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)? _____

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: _____]