



Penobscot Nation Department of Social Services
9 Sarah Springs Drive, Indian Island, ME 04468
Telephone: (207) 817-7492 Fax: (207) 817-7490

Parent Partner Referral Form

All Our Relations *Thriving*

Participant's Legal Name: _____ Date of Referral: _____

Birthdate: _____ Phone numbers: _____ Email address: _____

Mailing Address: _____

Physical Address: _____

Penobscot Tribal member: YES NO

Household member a Penobscot Tribal member: YES NO

Referred To: Alivia Moore, Family Advocate & Prevention Coordinator
9 Sarah Springs Drive, Indian Island, ME 04468
(207) 745-6644 alivia.moore@penobscotnation.org

Referred By: [Service provider's name, organization, address, phone number, & email]

How would a Parent Partner be beneficial for this family:

Authorization: I, _____ [Client's Name], give my permission to _____ [Service Provider's Name], to release this information to Alivia Moore, Family Advocate & Prevention Coordinator. The information is to be used to assist me in monitoring and coordinating my health care and social service needs.

Signature of Participant: _____ Date: _____

WITHDRAWAL OF AUTHORIZATION

I, _____, am canceling the further use of this authorization to Request/Release Information Form as of this date _____.

Signature of Participant: _____ Date: _____

TO BE COMPLETED BY PARENT PARTNER PROGRAM

Parent Partner Follow-up (summary of efforts to contact, eligibility, needs, etc.):

Date Referral Received: _____

Eligible for services: YES NO If no, why and what other referrals were given: _____

If yes, initial meeting date: _____

Parent Partner's Printed Name: _____

Parent Partner's Signature: _____