



REFERRAL FORM

Please email all referrals to jared.dolley@ucpofmaine.org or fax to 207-941-2955

Client Name: _____ Date: _____

Address: _____ City/Town/Zip _____

DOB: ____/____/____ SSN: _____ Sex: Male Female

Referred By: _____ Role: _____ Phone # _____

Guardianship: **DHHS** **Sole** **Shared** (Please include names and contact information for both parents)

Parent <input type="checkbox"/>	Name:	
DHHS <input type="checkbox"/>	Address	
Foster Parent <input type="checkbox"/>	Phone Number	Cell Number
Client <input type="checkbox"/>	Work number	Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Legal Guardian <input type="checkbox"/>		

Parent <input type="checkbox"/>	Name:	
DHHS <input type="checkbox"/>	Address	
Foster Parent <input type="checkbox"/>	Phone Number	Cell Number
Client <input type="checkbox"/>	Work Number	Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Legal Guardian <input type="checkbox"/>		

Parent <input type="checkbox"/>	Name:	
DHHS <input type="checkbox"/>	Address	
Foster Parent <input type="checkbox"/>	Phone Number	Cell Number
Client <input type="checkbox"/>	Work Number	Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Legal Guardian <input type="checkbox"/>		

INSURANCE INFORMATION

Primary Insurance:		Primary Insurance Phone Number:
Claims address:		
Policy Holder Name: (must complete relationship section for the subscriber if other than self)		
Primary Policy No.:	Primary Policy Group No.:	
Effective date of coverage:	Deductible amount:	Deductible met:
Co-Pay amount:	Co-Insurance amount:	Annual limit:
Managed Care Name:	Managed Care Phone No.:	
Authorization required: <input type="checkbox"/> Yes <input type="checkbox"/> No Authorization No:		
Total sessions authorized:	Authorization start date:	Expiration date:

Secondary Insurance:		Secondary Insurance Phone Number:
Claims address:		
Policy Holder Name: (must complete relationship section for the subscriber if other than self)		
Secondary Policy No.:	Secondary Policy Group No.:	
Effective date of coverage:	Deductible amount:	Deductible met:
Co-Pay amount:	Co-Insurance amount:	Annual limit:
Managed Care Name:	Managed Care Phone No.:	
Authorization required: <input type="checkbox"/> Yes <input type="checkbox"/> No Authorization No:		
Total sessions authorized:	Authorization start date:	Expiration date:

Diagnostic Assessment: Y / N Completed by: _____

Diagnosis: _____

Date of Diagnosis: _____

Case Manager _____

Other Agencies involved with currently: _____

Other Agencies involved with in the past: _____

PROGRAMS REFERRED TO:

- Children's Case Management
- Behavioral Health Home (Children's)
- Adult Case Management for Adults with Developmental Disabilities
- Home & Community Treatment (HCT)
- Outpatient Therapy: Individual Group Family Assessment Vineland Assessment
- RCS Specialized: School Home
- RCS: School Home
- Day Treatment
- Speech Therapy/Assessment

Reason for Referral (symptoms, behaviors, type of treatment requested): _____

How did you hear about us? Flyer/Advertisement Newsletter UCP Website Search Engine
 Social Network Friend/Family Member Event PCP Other Provider Other

Completed by UCP Employee (Please print): _____