700 Mt. Hope Avenue, Suite 320
Bangor, ME 04401
Phone: 207-941-2952
Fax: 207-941-2955
www.ucpofmaine.org

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 ☐	Name:	
DHHS ☐	Address	
Foster Parent ☐	Phone Number	Cell Number
Client ☐	Work number	Ok to leave a message? ☐ Yes ☐ No
Legal Guardian ☐		

Parent ☐	Name:	
DHHS ☐	Address	
Foster Parent ☐	Phone Number	Cell Number
Client ☐	Work Number	Ok to leave a message? ☐ Yes ☐ No
Legal Guardian ☐		

Parent ☐	Name:	
DHHS ☐	Address	
Foster Parent ☐	Phone Number	Cell Number
Client ☐	Work Number	Ok to leave a message? ☐ Yes ☐ No
Legal Guardian ☐		

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: ☐Yes☐ 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: ☐Yes☐ No	Authorization No:	
Total sessions authorized:	Authorization start date:	Expiration date:

Diagnostic Assessment: ☐ Y / ☐ N Completed by:_____

Diagnosis:_____

Date of Diagnosis: _____

Case Manager_____

Primary Care Physician _____

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:_____

_____

_____

_____

_____

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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): _____