PORT RESOURCES
opening doors | improving lives

280 B Gannett Drive
South Portland, Maine 04106

ph 207.828.0048
fax 207.772.3743

Home & Community Based Services Referral

Date Received (office use):

Service requested		
☐ **Residential**	☐ **Day Program** *(center based)*	☐ **Shared Living**
☐ **Home Supports** *(private home)*	☐ **Community Supports** *(community based)*	☐ **Achieving Independence Maine (AIM)**

Funding Type:	☐ **Section 21 Waiver**	☐ **Section 29 Waiver**	☐ **Private Pay**

Client		
Client Name:	Date of Birth:	Social Security Number:
Physical Address:		
Mailing Address (if different than above):		
Phone:	May we leave a message?:	
Email:		
Emergency Contact (name and phone number):		
Identified Gender:	Primary Language/Method of Communication:	
Do you require any special accommodations (including interpreter services)? Please describe:		
Primary Care Doctor (name, address, phone, fax):		
Psychiatrist (name, address, phone, fax):		
Pharmacy (name, address, phone, fax):		
Other specialists involved (name, address, phone, fax):		
Is Port Resources currently providing services to client? If so, please note service(s):		
Current Diagnoses (if known):	**For office use:** **Preliminary Diagnosis Code:**	
Does this person have significant medical needs, behavior characteristics or challenging behaviors?		
Does this person have a Safety Device Plan, Positive Support Plan (levels 1-2) or a Behavior Management Plan (levels 3-5)? If yes, please include the plan level/type and the date of approval:		

Parent or Legal Guardian				☐ **Client is self guardian**
Guardianship status:	Full ☐	Shared ☐	Limited ☐ If limited, please explain:	
Name:	Relationship to client:			
Phone:	May we leave a message?:			
Email:	Fax:			
Mailing Address:				
Name of Co-Guardian (if applicable):				

Is there anybody else who is responsible for the person this referral is for (such as a foster parent, an in-home care provider, Power of Attorney, etc.)? If yes, list all contact information.

****ALL INFORMATION REQUIRED****

Case Manager ☐ **Check here if same as guardian information**	
Name:	Phone:
Email:	Fax:
Mailing Address:	
Representative Payee ☐ **Check here if same as guardian information** ☐ **Check here if same as Case Manager information**	
Name:	Phone:
Email:	Fax:
Mailing Address:	

Insurance	
Does this client have MaineCare? ☐ YES ☐ NO	**MaineCare #:**
Does this client have Medicare? ☐ YES ☐ NO	**Medicare #:**
Does this client have other insurance, such as Anthem, Harvard Pilgrim, etc.? ☐ YES ☐ NO If yes, fill in all fields below	
Insurance Company Name:	**Policy Holder:**
Member ID #:	**Payer ID/Issuer # (5 digits):**

****ALL INFORMATION REQUIRED****

Please include copies of all insurance cards. Port Resources must receive copies of all insurance cards prior to the start of service. Not submitting copies of insurance cards could result in a delay of services.

Disposition of Referral
(for office use only)

☐ **Reviewed by Director of HCBS** (or his/her designee) ___/___/___ _____
Date Initial

☐ **Insurance confirmed** ___/___/___ _____
Date Initial

☐ **Client Information entered** ___/___/___ _____
Date Initial

☐ **Identified Program:** _____