280 B Gannett Drive
South Portland, Maine 04106

ph 207.828.0048
fax 207.772.3743

Referral for Port Resources Services

Date Received (office use):

Service(s) requested (please select at least one service):		
☐ Residential - Include program name, if known:	☐ Shared Living – Include provider name, if known:	☐ Port Place Day Program
☐ Independent Living Supports with housing (AIM)	☐ Behavioral Consultation	☐ Psychological Consultation
☐ Independent Living Supports without housing	☐ Medication Management	☐ Outpatient Counseling

If you have ever received or are currently receiving Port Resources services, list them here, including dates:		
Name:	Birthdate:	Social Security Number:
Physical Address:		
Mailing Address (if different than above):		
Phone:	May we leave a message? ☐ Yes ☐ No	
Email:		
Emergency Contact (name and phone number):		
Primary Language/Method of Communication:		
Sex: ☐ Male ☐ Female Must match insurance records to be processed	Identified Gender:	☐ **AMHI/Riverview Class Member**
Do you require any special accommodations (including interpreter services)? Please describe:		
Name and role of person making referral (if not client):		
Phone:	May we leave a message? ☐ Yes ☐ No	
Email:		

Please list all active insurance policies and funding types **By submitting this information, you acknowledge that Port Resources may be contacting your insurance carriers to determine coverage.**			
Do you have MaineCare? ☐ Yes ☐ No		MaineCare #:	
Do you have Medicare? ☐ Yes ☐ No		Medicare #:	
Insurance Company Name:		Policy Holder:	
Member ID #:		Payer ID/Issuer # (5 digits):	
Funding Type, if applicable:	☐ Section 21 Waiver	☐ Section 29 Waiver	☐ Private Pay

****ALL INFORMATION REQUIRED****

Please include copies of insurance cards. Not submitting copies of insurance cards could result in a delay of services.

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Parent or Legal Guardian	☐ **Person is self-guardian**
Name:	Relationship:
Phone:	May we leave a message? ☐ Yes ☐ No
Email:	Fax:
Mailing Address:	
Case Manager	☐ **Check here if same as guardian**
Name:	Phone:
Email:	Fax:
Mailing Address:	
Representative Payee	☐ **Check here if same as guardian** ☐ **Check here if same as Case Manager**
Name:	Phone:
Email:	Fax:
Mailing Address:	
Referral Information	
Current Diagnoses (if known):	
Does this person have significant medical needs, behavior characteristics or challenging behaviors?	
Primary Care Doctor (name, address, phone, fax)	
Psychiatrist (name, address, phone, fax)	
Pharmacy (name, address, phone, fax)	
Other specialists involved (name, address, phone, fax)	