HIGHER GROUND SERVICES
235 Center St. Brewer, ME 044012
Phone: 207-561-9496 Fax: 207-561-9498

REFERRAL FORM

Client Name: _____
First Middle Last

Services: Mental Health / Substance Abuse / Vineland / Level of Care

Gender: M / F
Transgender
Nonbinary
Fluid

Client Phone: Home _____ Cell/Secondary Number _____

Client Address: _____

Client Date of Birth: _____ Client Social Security Number: _____

Client Legal Guardian: _____ Email Address _____

INSURANCE INFORMATION:

Primary Company Name: _____ Primary Insured ID#: _____

Provider/Behavioral Health Phone: _____ Other Phone: _____

Secondary Company Name: _____ Secondary Insured ID#: _____

Provider/Behavioral Health Phone: _____ Other Phone: _____

Name of Insured: _____ Relationship: _____ Primary / Secondary / Both

Insured DOB: _____ Insured SS#: _____ Insured Phone: _____

Insured Address: Same as Client OR: _____

REFERRAL SOURCE

Date: _____ Referred By: Name _____ Phone: _____ Email: _____

For Case Management Referrals: Behavioral Health Assessment in last year? Y/N
Date of Assessment: _____ Agency/Hospital: _____ Dx: _____

Please attach any appropriate signed releases for information

Comments/Scheduling Consideration Requests

_____
_____
_____
_____
_____
_____

FOR HGS OFFICE USE ONLY
Date Received: _____ Clinician Assigned: _____ Date/Time 1st DOS: _____
APS case ID#: SA: _____ MH: _____ CFSN Submission Date: _____ Dx: _____