

RISE UP Recovery Referral for Peer Services

Participant Full Name: _____

Date of Birth: _____

Referral Source: _____

Employer/Occupation (Present): _____

Address: _____

Phone Number: _____ Email Address: _____

Insurance/Medicaid Information- Provider: _____

Subscriber or Medicaid ID Number: _____ Date verified: _____

Primary SUD Diagnosis (Include diagnostic codes) _____

Desired services:

Check services (1:1 services only but can attend group with participant)

_____ education

_____ advocacy

_____ mentoring

_____ attending recovery and other support groups

_____ accompanying participant to appointments that support recovery

_____ assistance in accessing resources

_____ recovery support to assist a person in the transitioning to/from treatment

***Referral must include a comprehensive assessment that indicates at least a risk rating of 1 in Dimensions 4, 5, or 6 and must include recommendation for peer services.**

If a person needs a comprehensive assessment you can contact Program Director Tiffany Neuharth .

Questions can be directed to Tiffany Neuharth at tiffany@riseuprecoverymn.com

Phone: 651-829-9155