Cenpatico
Improving Lives.

Specialty Provider Referral Checklist

Date: Click here to enter a date.

Referred By:

ICCA Name:	
ICCA Location:	
Case Manager:	Phone:
Email Address:	Fax:

Referral Reviewed By:

Name:	Credentials:
Signature:	Date: Click here to enter a date.

Referral For:

Member Name:		
DOB:	CIS:	AHCCCS:
BHC: ☐ Child ☐ SMI ☐ GMH ☐ SA		
Guardian (if applicable):		Phone:
Address:		
Cultural & Language Needs:		
Current Dx Codes:		
Next ART/CFT Meeting (if available): Click here to enter a date.		
What date was coordination with ICC Agency and Specialty Agency completed: Click here to enter a date.		
Reason for Referral:		

Requested Services: Service Codes are NOT required

Please check appropriate service category and identify frequency needed. For example: Check Treatment Services and enter 1-4x per month on the Frequency line.

☐**Treatment Services -** Frequency: ______________________________

(BH Counseling & Therapy; Assessment, Evaluation & Screenings; Other, Professional)

☒**Rehabilitation Services** - Frequency: 1 to 10 Days

(Skills Training & Development; Psychosocial Rehabilitation; Living Skills Training; Cognitive Rehabilitation; Health Promotion (includes medication training & support services); Psychoeducational Services & Ongoing Employment support)

☐**Medical Services** - Frequency: _________________________

(Medication Services; Laboratory, Radiology & Medical Imaging; Medical Management; Electroconvulsive Therapy)

☒**Support Services** - : 1 to 10 Days

(Case Management; Personal Care Services; Family Support; Peer Support; HCTC; Unskilled Respite Care; Supported Housing; Sign Language or Oral Interpretive Services; Transportation)

☐**BH Residential Services** - Frequency:___________________

(BH Residential Facility, without Room & Board; Mental Health Services NOS)

☐**BH Day Programs** - Frequency:_________________

(Supervised BH Treatment & Day Program; Therapeutic BH Services & Day Program; Community Psychiatric Supportive Treatment & Medical Day Program)

Required documentation from ICC Agency:

- ☐ Service Plan listing [Specialty Agency] services - **Requires BHP Signature**
- ☐ Current Assessment - **Requires BHP Signature**
- ☐ Demographic
- ☐ Release of Information listing [Specialty Agency]

For Out of Home Services, please provide:

- ☐ Physical (dated within one year)
- ☐ TB Test (dated within one year)
- ☐ SNCD (Youth Only)

To be filled out by [Specialty Agency]:

Date Referral Received: Click here to enter a date.

Referral Accepted:

☐Yes - First Appointment Date & Time:

☐No - Reason not accepted:

Specialty Agency Section Completed by:

Name:	Credentials:
Signature:	Date: Click here to enter a date.