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| **Specialty Provider Referral Checklist** |
| Date: Click here to enter a date. |

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| **Referred By:** | |
| ICCA Name: | |
| ICCA Location: | |
| Case Manager: | Phone: |
| Email Address: | Fax: |

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| **Referral Reviewed By:** | |
| Name: | Credentials: |
| Signature: | Date: Click here to enter a date. |

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| **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: | | |

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| **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:  (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** - Frequency:  (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) |

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| **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] |

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| **For Out of Home Services, please provide:** |
| Physical (dated within one year) |
| TB Test (dated within one year) |
| SNCD (Youth Only) |

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| **For Housing Provider Services, please provide:** |
| Vulnerability Index-Service Prioritization Assistance Decision Tool (VI-SPDAT) |
| Income Verification |
| SMI Determination |

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| Chronically Homeless  Homeless  Shelter  Hospital/Jail  BHRF or Substance Use Treatment Center  Transitional Housing |
| County Preference: Property Preference (1st three choices): |

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| **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: |

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| **Specialty Agency Section Completed by:** | |
| Name: | Credentials: |
| Signature: | Date: Click here to enter a date. |