



Application

Student Information

Eligibility Information

Your Name:

Date of Birth:

Address:

City, State, Zip:

Telephone #:

Email:

Yes No

Are you on AHCCCS?

Yes No

Are you an adult member of a GMH/SA TXIX or SMI program?

Health Plan:

Behavioral Health Provider:

Provider Telephone #:

Case Manager Name:

By providing the above information, I give Camp Wellness permission to contact me and to release and/or exchange information with my provider to coordinate my referral to Camp Wellness. I can opt out anytime and my information will remain private.

Applicant Signature

Date

Consented via phone

For Providers

Please provide the following documents to complete a referral to Camp Wellness:

- Specialty Agency Provider Referral Checklist.
- Demographic including ICD-10 codes, student's current mailing address and contact information.
- Current Annual Update (Part E) or Assessment (Part B Core Assessment) signed by a BHP.
- Individual Service Plan with a treatment goal for Camp Wellness and list Peer Support (H0038, H0038 HQ), Skills (H2014, H2014HQ), Health Promotion (H0025, H0025HQ) with attendance frequency per month, signed by the member and a BHP.
- Signed & dated Release of Information Form naming Camp Wellness.
- Sign and return this application with the required documents via fax to 520-396-2306 or secure email to fcmlreferrals@email.arizona.edu.

Questions? Call 520-396-2310/toll free 1-844-396-2310, www.campwellness.org