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| **PMF 3.3.2 - Specialty Provider Referral Checklist** |
| Date: Click here to enter a date. | Specialty Agency Referred To/Staff Contact: University of Arizona Workforce Development Program |

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| **Referred By:** |
| ICCA Name: | ICCA Location/Address:  |
| Recovery Coach: | Phone: |
| Email Address: | Fax: |

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| **Referral Reviewed By:** |
| Name: | Credentials: | Signature: |
| Phone:  | Email Address:  |

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| **Referral For:** |
| Member Name: | Member Physical Address:  | Member Phone:  |
| DOB: | AHCCCS: |
| BHC: [ ]  Child [ ]  SMI [ ]  GMH [ ]  SA |
| Guardian (if applicable): | Guardian Address:  | Guardian Phone:  |
| Address: |
| Cultural & Language Needs: |
| Current Dx Codes: |
| Next ART/CFT Meeting (if available, if no date type in NA): 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: Integrated Healthcare Recovery Support Specialist Institute |

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| **Requested Services: Service Descriptions are Required, Billing Codes are not Required** |
| Please input service frequency next to the service descriptions pertaining to the referral. For example: Next to Living Skills in the frequency cell enter in 1-4x per month. Do this for all services that are on ISP regarding this referral.  |
| **Service Category** | **Service Description** | **Frequency** | **Service Description** | **Frequency** |
| Treatment Services | BH Counseling/Therapy |  | Evaluation and Screenings |  |
| Assessment |  | Other/Professional |  |
| Rehabilitation Services | Skills Training & Development | 1-3 times a week for 6 weeks | Cognitive Rehabilitation |  |
| Psychosocial Rehab |  | Health Promotion |  |
| Living Skills Training |  | Pre-Employment  |  |
| Cognitive Rehabilitation |  | Ongoing Employment |  |
| Health Promotion |  |  |
| Medical Services | Medication Services |  | Laboratory |  |
| Radiology/Medical Imaging |  | Medical Management |  |
| Electroconvulsive Therapy |  |  |
| Support Services | Case Management |  | Personal Care Services |  |
| Family Support |  | Peer Support | 1-3 times a week for 6 weeks |
| Home Care Training to Home Care Client |  | Unskilled Respite |  |
| Supported Housing |  | Sign Language/Interpretive |  |
| Transportation |  |  |
| BH Day Program | Supervised BH Treatment and Day Program |  | Therapeutic BH Services and Day Program |  |
| Community Psychiatric Supportive Treatment and Medical Day Program |  |  |
| BH Residential Services | Behavioral Health Residential without R/B |  | Mental Health Services NOS |  |

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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 (dates 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 |
| [ ]  Chronically Homeless [ ]  Homeless [ ]  Shelter [ ]  Hospital/Jail [ ]  BHRF or Substance Use Treatment Center [ ]  Transitional Housing  |
| County Preference: Property Preference (1st three choices): |
| Other Household Members  |
|  Name  | Date of Birth  |  Male/Female |  Relationship to HH |
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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. |