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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. |