COLLEGE OF MEDICINE TUCSON
Family & Community Medicine

Application

Student Information

Your Name:

Date of Birth:

Address:

City, State, Zip:

Telephone #:

Email:

Eligibility Information

Are you on AHCCCS? ❑ Yes ❑ No

Are you an adult member of a GMH/SA TXIX or SMI program? ❑ Yes ❑ No

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 520-621-6663 or secure email to fcmreferrals@email.arizona.edu.

Questions? Call 520-621-7473/toll free 1-877-535-6170, www.campwellness.org