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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) |
| [x] **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) |
| [x] **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:** |
| [x]  Service Plan listing [Specialty Agency] services - **Requires BHP Signature** |
| [x]  Current Assessment - **Requires BHP Signature** |
| [x]  Demographic |
| [x]  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. |