Request for Direct Support or Specialty Provider Services

Identified Provider: _____ Date of Referral: _____

Member Information

Child's Name: _____ Date of Birth:_____

AHCCCS ID#:_____ Age:_____

Child's Physical Address:_____

Phone# _____ Child's Primary Language: _____

Male ☐ Female ☐ Cross System Involvement: DDD ☐ JPO ☐ DCS CHP ☐

Guardian's Information

Guardian's Name:_____ Best time to contact the guardian: _____

Guardian's Address (if different than above):_____

Guardian's Phone# (if different than above): _____

Guardian's Relationship to the Child:_____Guardian's Primary Language _____

Assigned Provider Information

Assigned Provider Agency: _____

Facilitators Name:_____Fax #: _____

Facilitators Direct Phone#:_____ Facilitator's Cell Phone#:_____

Facilitator's Email Address: _____

High Needs Case Management Provider Agency (if applicable): _____

Name of High Needs Case Manager (if applicable): _____

Description of the services being requested:

Why does this child need this service?

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Please list all of the Child's Diagnosis Code(s):

Additional Comments:

Please fax this referral form to the Direct Service Provider with a copy of the following documents. If there are any documents missing, please comment on why:

☐ CFT service plan/CFT Notes,

☐ Strengths, Needs and Cultural Discovery (ages 6-17)

☐ Current assessment or most recent annual update,

☐ Crisis/Support Plan

☐ Most Recent CALOCUS

☐ Current Psychiatric Notes and Evaluation (if applicable)

Facilitator's Signature and Date: _____

Clinical Supervisor/Clinical Director Signature and Date: _____

This section is to be completed by the receiving provider:

☐ *Referral Accepted***

☐ *Referral Declined***

If declined, please provide a reason for decline: _____

**The receiving agency will notify provider of referral acceptance or denial within 3 business days.