Referral for Services Form

Referrals must be submitted on this form via
Fax: 602.795.1663 or email: bhservices@seekarizona.org

Name ______________________________ Date of Birth ________________ Age ____ Gender____

CIS# ______________________________ AHCCCS # ________________ SSN# ______________

Eligibility: T19 ____ T21____ Non T19_____ Other Agency Involvement____________________________

Client's Current Address____

City ____________________ State ______ Zip ________ Phone_____________________________

Parent/Legal Guardian ____________________________ Phone_____________________________

Address, if different____

Is this client in a group home? ☐ Yes ☐ No

Is the client in an Residential Treatment Center (RTC)? ☐ Yes ☐ No What level of RTC?__________________

Cultural and language considerations: ☐ Yes ☐ No specify language/need ______________________________

Diagnosis Code(s): ____

What service(s) do the client and team want?

- ☐ Functional Behavior Assessment (FBA)
- ☐ Behavior Coaching
- ☐ Life Skills
- ☐ BRIEF Early Intervention Program
- ☐ Individual and Family Counseling
- ☐ Group Counseling
- ☐ Other ________________

Please refer to S.E.E.K. Arizona's Behavioral Health Services Guide to determine appropriateness of services.

Is the client/team in agreement with the service requested? ☐ Yes ☐ No

Previous services with S.E.E.K. Arizona? ☐ Yes ☐ No What services? ____________________________

Please give a brief history of previous services to meet the needs of the client including reasons for discharge:

What is the client's past and present history (past 90 days) of danger to self/others symptoms and behaviors? (Specify noted behaviors together with frequency, duration, and intensity.)

What services is the client currently receiving?____

Is the client involved in any community supports? What?____

What is the client's availability for services?

Sunday:	☐ AM	☐ Mid-Day *(12-3pm)*	☐ PM
Monday:	☐ AM	☐ Mid-Day *(12-3pm)*	☐ PM
Tuesday:	☐ AM	☐ Mid-Day *(12-3pm)*	☐ PM
Wednesday:	☐ AM	☐ Mid-Day *(12-3pm)*	☐ PM
Thursday:	☐ AM	☐ Mid-Day *(12-3pm)*	☐ PM
Friday:	☐ AM	☐ Mid-Day *(12-3pm)*	☐ PM
Saturday:	☐ AM	☐ Mid-Day *(12-3pm)*	☐ PM

Where would the team like for services to take place?

- ☐ Home
- ☐ Group Home
- ☐ School
- ☐ S.E.E.K. Arizona's Facility
- ☐ Other: ______________________________

Describe the goals of services and desired outcomes:

II. Information on Person Making Referral

Name and Title ____

Affiliated Agency ______________________________ Phone ____________ Fax ____________

Agency Mailing Address:____

Email Address____

Supervisor:______________________________ Email address:______________________________

Referring Individual's Signature ______________________________ Date____________

Referral packets will be considered complete if they contain the following:

1. _____Core Assessment (If the Core Assessment is more than 1 year old, a Current Part E Annual Behavioral Update & Review Must be submitted.) ***Date of most recent assessment***______________________
2. _____Behavioral Health Service Plan (CCS must be listed in the service plan along with the services being requested) ***Date of most recent ISP***______________________
3. _____Psychiatric Evaluation
4. _____Psychiatric Progress Notes
5. _____Crisis & Safety Plan
6. _____Copy of client demographics ***Date of Demographics (must match Part E)***______________________
7. _____Copy of CASII Report (If applicable) ***Date of most recent CASII (must match Part*** *E)*______________________

Referral Accepted: ☐ Yes ☐ No Date:____________ Accepted by:____________