

**OPEN UNTIL 01/02/17**

**EXHIBIT 580-1<sup>1</sup>**

**REFERRAL AND INTAKE PROCESS FORM**

<sup>1</sup> Delete form not necessary to provide for referral processes.

**EXHIBIT 580-1  
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<b>-Information on Person Making Referral</b>
Date: _____
Time (24 hour clock): _____
Type of Service Requested: _____
Name and Title: _____
Affiliated Agency: _____
Phone: _____
Fax: _____
Type of Service Requested: <input type="checkbox"/> One time consultation <input type="checkbox"/> Ongoing Behavioral Health Services

<b>Behavioral Health Services Requested</b>
(Check all that apply): <input type="checkbox"/> Treatment Services: Choose One General description of service(s) requested: Choose One <input type="checkbox"/> Rehabilitation Services: Choose One <input type="checkbox"/> Medical Services: Choose One <input type="checkbox"/> Support Services: Choose One <input type="checkbox"/> Behavioral Health Day Programs: Choose One

<b>Information on Person Being Referred for Services</b>
Last Name: _____
First Name: _____
Gender: Choose One
Home Phone: _____
Cell Phone: _____
Primary Language: _____
Address: _____
City: _____
State: _____
Zip: _____
Current Location (if not address above): _____
If female, are you pregnant?: Choose One
Intravenous Drug (IV) use: Choose One
Parent/ Legal Guardian (if applicable): _____
Parent/ Legal Guardian phone : _____
Identify individual(s) that the member, parent or guardian may wish to be invited to initial appointment with person (Include phone): _____
Person/Parent/Guardian is aware of Referral: Choose One
Cultural and Language Considerations: Choose One
If yes interpreter needed: Choose One

<b>Accommodation Needs</b>
Mobility Assistance: Choose One
If yes, identify assistance needed: _____
Visual Assistance: Choose One
If yes, identify assistance needed: _____
Hearing Impairment Assistance: Choose One
If yes, identify assistance needed: _____
Developmental or Cognitive Impairment: Choose One

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**Payment Source**

AHCCCS: Choose One
AHCCCS ID # (if applicable): _____
Self Pay: Choose One
Private insurance: Choose One
Health Plan: Choose One
Medicare: Choose One
Substance Abuse Block Grant Block Grant Eligible <sup>2</sup> : Choose One
Other: _____
Primary Care Physician (PCP): _____
PCP Phone / Fax: _____
Name of Private Insurance and/or Health Plan: _____
Reason for Referral: _____

**Unable to Contact Person Being Referred for Services**

If the person is taking medications to treat a behavioral health condition, does she/he have an adequate supply for the next 30 days? Choose One
If no, when will she/he exhaust the current supply of medication? _____
If currently receiving services will there be any other interruptions that need to be addressed? _____
Outreach Attempts: _____
Type of Outreach and Engagement conducted (check all that apply): <input type="checkbox"/> Phone Call Number of calls: _____ <input type="checkbox"/> Face to Face visit attempts Number of attempts: _____
If unsuccessful, state reason why (check all that apply): <input type="checkbox"/> No answer to phone call <input type="checkbox"/> Person being referred already enrolled in behavioral health services <input type="checkbox"/> Telephone disconnected <input type="checkbox"/> Person being referred refuses behavioral health services <input type="checkbox"/> Message(s) left with no response
Referral Source Notified of Unsuccessful Contact: Choose One
If yes, list alternate contact information obtained: _____

**\*\*\*If Unable to Contact Stop Here\*\*\***

**Information to be Collected by Network Provider**

Date: _____
Time (24 hour clock): _____
If applicable, name and contact information of the provider that will assume primary responsibility for the person's behavioral health care: _____
Type of Appointment: <input type="checkbox"/> Immediate <input type="checkbox"/> Urgent <input type="checkbox"/> Routine
Available Intake Appointment Offered: Choose One If yes, specify date, time, place: _____
Scheduled Intake Appointment: Choose One If yes, specify date, time, place: _____
If not Referred for Appointment specify why: _____
Other Disposition, explain: _____

<sup>2</sup> Clarification to specific line of funding.

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**Outcome (within 30 days)**

**Intake Appointment Kept: Choose One**

**If no, why (Check all that apply)**

- Rescheduled by Provider
- Rescheduled by Person being referred
- Cancelled without rescheduling by Person being referred
- Person being referred was a "no show"

**If no show, specify outreach and engagement efforts (including number of attempts and type):** \_\_\_\_\_

**Was assessment completed the same day as intake: Choose One**

**If no, date assessment scheduled for:** \_\_\_\_\_

**\*\*\*Please return form to referral source with "Action Take" section completed.\*\*\***