mercy care

Request for Direct Support or Specialty Provider Services

Identified Provider: ______________________________ Date of Referral: ___________

Member Information

Youth's Name: ____ Date of Birth:__________

AHCCCS ID#:__________________ CIS#:_________________ Age:________

Youth's Physical Address:____

Phone# _______________________ Youth's Primary Language: ______________________

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

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 Youth:_________________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:

Frequency, days, and times of Services needed:

Why does this youth need this service?

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

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

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 (if CASII 4, 5, or 6)

__Current assessment or most recent annual update

__Crisis/Support Plan

__CASII

__ Current Psychiatric Notes and Evaluation (if applicable)

__ MMWIA Prioritization Form for MMWIA Providers (AYFS, CFSS, Touchstone/WIT, Youth and Families First, New Hope of Arizona, Youth ETC/Project Next Step, or A New Leaf/PACT)

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:____