CHEEERS REFERRAL FORM

www.cheeers.org

1950 W. Heatherbrae Dr. Suite 2 Phoenix, AZ 85015 602.246.7607 Referral Fax 602-424-6241
email CHEEERSREFERRALS@CHEEERS.ORG

Date of Referral: ______________ ____________________

Name of Person being referred: ____ Date of Birth_______/_______/ ___

AHCCCS ID: ____________________ Phone # (where the individual can be reached): ________________________

Address: ______________________________________ City: _____________ State: _____ Zip Code: ___________

Gender: □ Male □ Female □ Transgender Individual is: □ SMI / RBHA □ GMH/SA □ ALTCS

□ Health Plan coverages: Name of Health Plan or Benefit: ____

Required Documents for Referrals from Provider Agencies / Clinics / Health Plans

- □ Current Assessment (diagnostic evaluation)
- □ Current Individual Service Plan, Listing all Peer Delivered Services offered at CHEEERS ****see Notice Below ****
- □ Authorization to Release Information

*** **Notice**: As a Peer Operated Program following best practice standards, CHEEERS programming structure allows for member choice, therefore all Peer Delivered services offered at CHEEERS **must** be included in the ISP. (does not apply to ALTCS members or unless otherwise arranged/ authorized)*

Services listed on the ISP must include all of the following to allow for member choice: 1. Peer Support 2. Behavioral Health Day Treatment, 3. Skills Development 4. Psychoeducational/ Pre-Job Training and Development 5. Behavioral Health Prevention Education 6. Non-Emergency Transportation Services to engage in skill development activities or recovery activities.

To assist referring agencies, the attached service plan can be used as an addendum to the agencies current service plan for the individual. This service plan if signed by referring staff, individual receiving services and a BHP will meet the requirements and will prevent any interruptions in services or need to contact clinics or referring agencies for additional information.

Self-Referrals or Non- Provider Referrals:

For individuals not referred by a Provider Agency or who do not have a current assessment or ISP, CHEEERS will make arrangements for the individual to receive an assessment and have an individual service plan completed by a qualified BHP.

Referring Provider/ Site/Clinic: ___________________________________ Phone: ______________________

Name of Staff or person making the referral: _______________________________ Title:________________

Please send Referral Face Sheet and Required Documents to CHEEERSREFERRALS.org or fax to 602-424-6241

Note: For Peer Employment Training Referrals there is an additional form that must be completed and sent with this referral packet , form can be found at www.cheeers.org , Programs , Peer Employment Training

Individualized Service Plan (ISP) Addendum **Addition to Current Service Plan**

Name: ____________ AHCCCS ID# ____________ Provider/Agency ____________ Today's Date: ____________

Review Date (Objective Target Date):

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	Current Measure	INTERVENTIONS to MEET OBJECTIVES		Desired Measure	Achieved Measure (at target date)	Measure Met (Y/N)
		Specific Services and Frequency	Strengths Used			
1. Receive Peer Delivered Support Services- Client will develop skills to: cope, understand and manage symptoms or health conditions; communicate, develop or managed relationships; increase their ability to live independently; engage in employment or meaningful volunteer work experience; and allow them to participate in/ benefit from community activities, resources, events and /or supports.	0	Client will receive and engage in **any** peer delivered services provided/offered at a Peer Operated Agency that assists them in addressing the identified need. Those services include: 1. Peer Support (Individual & Group services), 2. Behavioral Health Day Treatment 3. Skill Development (Individual & Group services) 4. Psychoeducational/ Pre-Job Training and Development (Individual and Group Services) 5. Behavioral Health Prevention Education (Group) 6. Personal Care Services 7. Home Care Training 8. Non-Emergency Transportation Services to engage in skill development activities or recovery activities ☐Please Check if applies: This may also include Sign Language or Oral Interpretive Services provided by an outside vendor/agency if needed.		Up to 6 days per week based on member choice in support of Best Practice Principles	Ongoing	

☐ Yes, I am in agreement with the types and levels of services included in my service plan.

☐ No, I disagree with the types and/or levels of some or all of the services included in my service plan.

Person / Guardian Signature ______________________ Date: __________

CM/Care Coord/Assessor Signature: ______________________ Date: __________

BH Prof. Rev (MUST BE SIGNED BY BHP) ______________________ Date: ________(within 72 hours)