



"Share the values you grew up with"

Referral Cover Sheet

Thank you for inquiring about New Horizon Youth Homes Services. Attached is our Referral Packet. Please complete the Referral Form and send it along with the documents listed below. Having a complete referral packet will help us to bring services as soon as possible.

This cover sheet also serves as the fax cover sheet for your convenience.

To: NHCC Referral Coordinator

Phone: 480-722-2730

Fax: 480-664-4296

Email: Outpatient@nhccservices.org

From:

Date Sent:

Number of Pages:

Please attach the following required documents:

- 1. Referral Face Sheet
- 2. T/RBHA Treatment/Service Plan with specific services listed & RMBHS (signed by BHP and guardian.)
- 3. T/RBHA Annual Behavior Assessment (reviewed and signed by BHP)

Magellan referrals must also submit: Current Strengths Needs & Cultural Discovery Assessment (SNCD), CASII score

Additional documents will be required to complete once referral has been accepted into the program.

Updated information that is not currently addressed in the Annual Behavior Assessment: _____

This fax is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you have received this fax in error please notify the sender and destroy this message.



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Referral Face Sheet

| | | | | | | | | | | | | |
|--|---|--|--------------------------------|--|---|--|--|--|--|--|--|--|
| Client Name: | | | | | | | | | | | | |
| Current Residency/ Placement Address: | | | | | | | | | | | | |
| City: | State: | Zip: | Contact Phone Number: | | | | | | | | | |
| Client Date of Birth: | Age: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Client Ethnicity/ Race: Select | | | | | | | | | |
| Social Security Number: | Client Current Marital Status: Select | Is this a current client of NHCC? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| Diagnosis Codes ICD 10: | Special Needs: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain: | Preferred Language: | | | | | | | | | | |
| AHCCCS ID Number: | | AHCCCS Exp Date: | | | | | | | | | | |
| Is CPS/TSS Legal Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No | TSS/CPS Name: | TSS/CPS Contact Info: | | | | | | | | | | |
| Legal Guardian Name(s): | Relationship to client: | Contact Info: | | | | | | | | | | |
| Funding Agency/Source: Select | Case Manager: | Phone: Fax: | E-mail: | | | | | | | | | |
| Please check all that apply: Outpatient Programming: Clinical Services: <table style="width:100%; border:none;"> <tr> <td style="width:33%;"><input type="checkbox"/> Family Counseling</td> <td style="width:33%;"><input type="checkbox"/> Choice Program</td> <td style="width:33%;"><input type="checkbox"/> Adult Development Program (must include counseling referral)</td> </tr> <tr> <td><input type="checkbox"/> Individual Counseling</td> <td><input type="checkbox"/> Mentoring-ACHIEVE Program</td> <td><input type="checkbox"/> Adult Mentoring Program</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Intensive Mentoring-180 Program</td> <td></td> </tr> </table> | | | | <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Choice Program | <input type="checkbox"/> Adult Development Program (must include counseling referral) | <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Mentoring-ACHIEVE Program | <input type="checkbox"/> Adult Mentoring Program | | <input type="checkbox"/> Intensive Mentoring-180 Program | |
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| <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Mentoring-ACHIEVE Program | <input type="checkbox"/> Adult Mentoring Program | | | | | | | | | | |
| | <input type="checkbox"/> Intensive Mentoring-180 Program | | | | | | | | | | | |
| Presenting Issues/Goals: | | | | | | | | | | | | |
| Signature: | | Date: | | | | | | | | | | |