Hope Lives/Vive La Esperanza (HLVLE)

1551 W Van Buren St, Phoenix, AZ 85007
***Main Phone* # 855-747-6522, *FAX* # 602-388-1567**

Referral Packet Request & Checklist

PLEASE INCLUDE THIS FORM WITH THE REFERRAL PACKET; as the cover sheet and fax to Audrey Sambrano at: fax # 602-388-1567 or email to: astubbs@vivehopelives.org. Direct line 602-714-8165.

Date: _____

Service Recipient Name:

Best Contact Information for Member:

Clinic/Agency Name & address/Location:

Case Manager/E-mail address:

Clinic/Agency Phone #:

Clinic/Agency FAX #:

Clinical/Agency Director/E-mail address:

Date referral was requested by member:

Complete Referral Packet must contain all of the following items:

•1) **Individual Service Plan (ISP)/Treatment Plan** – needs to include **Peer Support** (this will cover both individual and groups), **Skills Training** (this will cover both individual and groups), **Transportation** - Non-emergency (A0120 and S0215). **Signed and dated by Member, Staff, and BHP, (TGC - please include Affidavit, if ISP specifies *"For Behavioral Health Professional Signatures see BHServicePlanAffidavit"*).**

•2) Assessment/Part E *(TGC – please include Affidavit)* - must cover ISP dates of service. **Signed and dated by Staff and BHP (TGC - please include Affidavit, if ISP specifies *"For Behavioral Health Professional Signatures see BHServicePlanAffidavit"*).**

•3) Releases of Information (ROIs) – (Health Home to Hope Lives)

All forms must include a valid signature both clinical and member, including signature date

Packets must be complete within 72 business hours

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Referral Questionnaire

Is Recipient currently on probation/parole? Yes No (circle one)

If "Yes," Probation/Parole Officer's Name:

_____

P.O.Phone #: _____ P.O. email address: _____

Surveillance Officer's Name:_____

S.O. Phone #: _____ S.O. email address: _____

Is Recipient a registered Sex Offender? Yes No (circle one)

Is Recipient represented by a Guardian? Yes No (circle one)

If "Yes," Guardian Name: _____

Guardian Phone #: _____

Is Recipient represented by an Advocate from the Office of Human Rights?

Yes No (circle one)

If "Yes," Advocate Name: _____

Advocate Phone#: _____ Advocate email address: _____

Is Recipient currently on Court Ordered Treatment? Yes No (circle one)

Please make sure to submit this form with the Referral Checklist.