



Thank you for choosing Cherishing Life Behavioral Home complete the attached Referral Form and send it along with the documents listed below. Having a complete referral packet will help us to begin services as soon as possible.

Please send the following required documents:

- ☐ . Completed Cherishing Life Behavioral Home Services Referral Face Sheet
- ☐ . T/RBHA Annual Behavior Assessment (reviewed and signed by BHP)
- ☐ . T/RBHA Treatment/Service Plan with RMBHS and specific services listed, i.e. Wellness, BHF, Counseling. (signed by BHP and guardian.)
- ☐ . Court Order for Guardianship (if the guardian is not the biological parent)

This Referral Cover Sheet can also serve as the fax cover sheet for your convenience.

To: Cherishing Life Behavioral Home
Services Intake Coordination

From: _____

Date Sent: _____

Phone: 623-440-1869

Number of Pages: _____

Fax: 623-440-1869

Email: info@cherishinglifehomes.com

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.



REFERRING AGENCY

Referral Date: _____

Please ✓ the referring agency: _____ Gila River _____ Pascua Yaqui _____ Salt River
(Intake Agency)

REFERRAL INFORMATION

Client Name: _____ Client Phone #: _____

Preferred Language: _____ Other Phone #: _____

Client Address: _____ City and Zip: _____

Address Directions: _____

Social Security #: _____ **AND AHCCCS ID#:** _____

Client Date of Birth: _____ **CIS ID:** _____

Guardian(s) Name: _____ Gender: _____ Client Age: _____

Guardian Phone #: _____

DCS/TSS Legal Guardian?: ☐ **Yes** ☐ **No** If **Yes**, please provide primary care giver's name and Phone #: _____

Emergency Contact(s): _____ Phone: _____

Reason for Referral: _____

Diagnosis Code(s): _____

Medications: _____

Allergies: _____

PCP Name: _____ PCP Phone #: _____

Services Requested:

☐ **Wellness Weekend/Community Based Support** (Respite, Psychosocial Rehabilitation, Case Mgmt, Transportation, & Med Assistance)

Wellness Scheduling Frequency: ☐ Every 2-3 weeks ☐ Once A Month ☐ Only On CM Approval

☐ **Building Healthy Families/In-Home Support** (Counseling, Case Mgmt, Family Support, Respite, Transportation, & Med Assistance)

☐ **Community Based Counseling** (Counseling, Case Management, Family Support, Transportation, & Medication Assistance)

REFERRING PROVIDER

Case Manager Name: _____ CM Phone #: _____

Signature: _____ CM Email: _____