Rev. 9/5/24

# Client Referral Form

Thank you for your choosing to enroll in services with Liv Well Behavioral.
Please make sure to complete this form in its entirety so services can begin as soon as possible.

| **CLIENT/GUARDIAN INFORMATION** | | | |
|---|---|---|---|
| Client Name: | | Date of Birth: | |
| Gender: | ☐ Male ☐ Female | Current School and Grade: | |
| AHCCCS ID #: | | Social Security #: | |
| Guardian(s) Name: | | | |
| Is Guardian DCS/TSS? ☐ Yes ☐ No | If yes, please provide caregiver's contact name and contact information below: | | |
| | | | |
| Contact #: | | Contact Email: | |
| Address: | | Apartment Unit/#: | |
| City: | | Zip Code: | |

| **SERVICES REQUESTED** | |
|---|---|
| ☐ **Enrichment Program** – Therapeutic After-School and Group counseling Program | ☐ **Empowerment Program** – Therapeutic Weekend and Group Counseling Program |
| • Psychoeducational Groups:<br>  ○ Expressive Arts<br>  ○ Group Coaching<br>  ○ Life Skills<br>• Self- Care<br>• Career Development<br>• Recreational Activities | • Social and Life Skill Development<br>• Self-Care<br>• Recreational and Community Activities<br>• Assistance with Self-Administration of Medication |
| ☐ **Engagement** – Mentorship Program | ☐ **Resources** – Therapeutic Activities and Family Assistance |
| • One on One Coaching<br>• Social and Life Skill Development<br>• Community Activities<br>• Volunteering<br>• Homework Help | • Family Building Games & Activities<br>• Family Behavioral Education and Activities<br>• Food Assistance<br>• Hygiene Items |

| **CLIENT REFERRAL INFORMATION** | | | |
|---|---|---|---|
| Reason for Referral: | | | |
| | | | |
| Diagnosis Code(s): | | | |
| Medications: | ☐ Yes ☐ No | If yes, please list: | |
| | | | |
| Additional Comments/Possible Barriers to Service: | | | |

| DOCUMENTATION | |
|---|---|
| Please send the items listed below to the email address and subject line provided. | |
| ☐ Completed Liv Well Referral Form | ☐ Court Order for Guardianship or Custody Agreement, if applicable |
| ☐ Comprehensive Assessment and/or Annual Update | ☐ Individual Service Plan with Program Goal/Objective |
| Email this completed referral form to: referral@livwellbhs.org | |
| Please use the email subject line: Liv Well Behavioral Intake Coordination | |

| REFERING PROVIDER INFORMATION | | | |
|---|---|---|---|
| Referring Provider Name: | | Agency: | |
| Contact #: | | Email Address: | |
| Referring Provider Signature: | | Date: | |

*Thank you!*