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

☐ After-School Program (Chandler Only)

- Psychoeducational Groups:
  - Expressive Arts
  - Group Coaching
  - Life Skills
- Self- Care
- Career Development
- Recreational Activities

☐ Respite Program (Weekend)

- Social and Life Skill Development
- Self-Care
- Recreational and Community Activities
- Assistance with Self-Administration of Medication

☐ Mentorship (Mesa Only

- One on One Coaching
- Social and Life Skill Development
- Community Activities
- Volunteering
- Homework Help

☐ Resources

- Family Building Games & Activities
- Family Behavioral Education and Activities
- Food Assistance
- 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!