Anything Is Possible Youth & Family Services, LLC. (AIP)

Referral Form

Fax referral to: (480) 632-1198 or Email to referral@aipservices.net

Today's Date: [Date]	Referral Source/Title/Phone: [Referral Source/Title/Phone #]
Organization: [Organization]	Fax #: [Fax #]

Services Needed: ☐ Counseling ☐ Mentoring ☐ Behavior ☐ Substance Abuse Counseling ☐ Mentoring - Saturday Program only
☐ Coach ☐ Transitional Living with Residential ☐ Transitional Living with out Residential ☐ Mentoring - Boxing Program only

CLIENT INFORMATION

Client's last name:	First:	Middle: [Choose an item]	Marital status:

AHCCCS ID:	CIS #:	ICD10 Code:	Birth date:	Age:	Sex:
[AHCCCS ID]	[CIS #]	[ICD10 Code]	[Birthday]	[Age]	○ M ◉ F

Physical Address: [address, city, st zip code]
Mailing Address: [if different from above]
Email Address: [client or parent/guardian]

Social Security no.:	Home phone no.:	Cell phone no.:
[SS#]	[Phone]	[Phone]

Reason for referral: [Provide referral information]

GENERAL INFORMATION – COMPLETE ENTIRE FORM

(Please give your insurance card to the receptionist.)

Guardian's Name:	Address (if different):	Home/Cell phone no.:	Work phone no.:	Employment:
[Guardian]	[Address]	[Phone]	[Phone]	[Employer]
Guardian's Name:	Address (if different):	Home/Cell phone no.:	Work phone no.:	Employment:
[Guardian]	[Address]	[Phone]	[Phone]	[Employer]

Household Language(s) (Parent & Children):

School/Grade Level or Employer of Client:

IN CASE OF EMERGENCY

Emergency Contact Name:	Relationship to patient:	Home phone no.:	Work phone no.:
[Friend or relative name]	[Relationship]	[Phone]	[Phone]

For AIP Use Only:

Date Referral Received: Date Referral Assigned:

Referrals that do not intake within 30 days will be placed on the inactive list and may need to be resubmitted by the provider.