



**212 E. OSBORN RD.
PHOENIX, AZ 85012
Phone: (602)248-0368
Fax: (602)**

REN SELF REFERRAL FORM

People being referred become members and are therefore eligible for all services REN provides.

As a REN member, one can participate in groups, classes, community activities, and 1 on 1 peer support at any REN site. REN collaboration is mutually beneficial, so please indicate the recovery goal you are seeking to achieve as a member of REN.

Recovery Goal: _____

Applicant Name: _____

Preferred Name: _____

Guardian Name: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

Email: _____

By signing below, I give permission for REN and my clinical team to communicate regarding my coordination of services. I also give REN permission to contact me by any means of communication listed above and to leave a message if necessary.

Applicant/Guardian Signature: _____

Clinic Name: _____

Clinical Team Representative Name: _____

Title: _____ Supervisor Name: _____

Clinic Site: _____ PNO: _____

Phone: _____ E-mail: _____

Check the applicable box indicating eligibility:

TXIX SMI

NTXIX SMI

Clinical Member Referral Signature: _____

Date: _____

(By signing you are providing authorization for REN to provide services to the person listed above.)

Please include the following documents to complete the referral and authorization for services and fax to (602)626-8379 or e- mail to membership@renaz.org.

- Demographic form or Face sheet
- Most Recent Part E (Assessment) with BHP signature or Affidavit
- Most recent Individual Service Plan ISP (Must be signed by individual or guardian)

Member services manager will contact the applicant for membership activation upon receipt of the documents listed above.