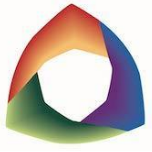


People Empowering People of AZ Inc.

Referral Documents Checklist

READ PRIOR TO SENDING A REFERRAL

ALL REFERRALS ARE PROCESSED IN THE ORDER IN WHICH THEY ARE RECEIVED

PROVIDING A COMPLETE REFERRAL SPEEDS UP THE REFERRAL PROCESS

Documents REQUIRED for a COMPLETE Referral;

- ☐ Participant Referral Information Form
- ☐ Consent to Release Information for Referral Source (If Applicable)
- ☐ Consent for Evaluation and Treatment for Guardian of Minor Child with Signature of ALL Guardian(s)
- ☐ Proof of Guardianship (If Applicable- Custody Documents, Notice to Provider)
- ☐ Birth Certificate
- ☐ Guardian Driver's License/ Government Identification Card
- ☐ Insurance Card
- ☐ Supporting Documentation (If Applicable- Treatment Plan, Assessments, Screening Tools, Safety/Crisis plan, Risk Assessment)

People Empowering People of AZ Inc.

Participant Referral Information Form

Date of Referral: ______________________________

Participant Information:

Participant's First and Last Name: ______________________________

Participant's Date of Birth: ______________________________

Participant's Address: ______________________________

Participant's Phone Number: ______________________________

Guardian(s) Information:

Guardian #1

Guardian's First and Last Name (if applicable): ______________________________

Guardian's Address: ______________________________

Guardian's Phone Number: ______________________________

Guardian #2

Guardian's First and Last Name (if applicable): ______________________________

Guardian's Address: ______________________________

Guardian's Phone Number: ______________________________

Insurance Information:

Insurance Company Name: ______________________________

Member ID number or Group ID number: ______________________________

Request(s)/Accommodation(s):

Deaf/Hard of Hearing/ Blind? ______________________________

Clinician Preference: Male Female N/A

What are the primary concerns to be addressed?

Referral Information:

Person or Agency making the initial referral for the Children's Program:

____

Date of Referral Request: ______________________________

Phone Number: ______________________________

Address: ______________________________

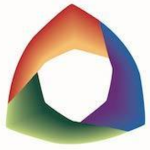
Relationship to the Participant (e.g. parent, doctor, therapist, etc.): ______________________________

How did you hear about us?: ______________________________

Referral Person Name	Referral Source Signature	Date

We appreciate you contacting us today! In addition to completing this form, please send the required documentation via the email or fax number below and someone will contact you for next steps.

Email pepchildren@pepofaz.com or Fax 480-999-3324



People Empowering People of AZ Inc.

Consent for Evaluation and Treatment for Guardian of Minor Child

Obtaining informed consent for treating minors can be difficult to navigate at times and can create potential legal and ethical concerns for the counselor and practice. Additionally, lack of appropriate communication and informed consent by both parents could be detrimental to the minor and their counseling treatment. For this reason, if parents are divorced or legally separated, BOTH must provide consent for treatment, unless otherwise specified in a Court Order. If this is the case, we require a copy of the Court Order for our records. If parents are married, only one parent is required to give consent for treatment unless the clinician determines a need for both parents to provide consent for counseling services (this may be determined during treatment). For more information, please see the following Arizona Revised Statutes: ARS 36-2272, ARS 25-401.

- I authorize People Empowering People of AZ, Inc. to provide evaluation and treatment services to the identified participant.
- I agree to participate in the treatment planning process to the best of my ability and encourage the participant to actively engage in the treatment process as well as let the provider know if situations occur that prevent participation.
- I understand that this consent will remain valid so long as the minor child is enrolled in AHCCCS, or until I withdraw consent.
- I understand that by signing this consent form, I am giving permission to AHCCCS, Arizona Department of Health Services, and all members of the clinical treatment team, to access the participant's information and records.
- I understand that all of the information gathered in the course of the participant's treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law.

Participant's First and Last Name: ____
Participant's Date of Birth: ____
Guardian's First and Last Name: ____
Guardian's Signature: ________________________________ Date: _________________

Document Used to Establish Guardianship/Legal Decision Making Authority:

____

Guardian's First and Last Name: ____
Guardian's Signature: ________________________________ Date: _________________

Document Used to Establish Guardianship/Legal Decision Making Authority:

____

******************************For Internal Use Only*****************************
Verification of Documents

________________________ ____________________________ ________________
Printed Name Signature Date

Form: Children's Program Referral Documents
Updated: 11/04/2021