RBHA and RSA/VR Referral Coordination Form

Member Name: ______________________________
Member Phone: ______________________________
DOB: _____________ **TXIX**:☐ **NTXIX**:☐
AHCCCS ID: ___________________________________

Site: ____
Clinical Team Member: ___________________________
Phone: ____
Clinical Team Member Email: ________________

Per the Covered Services Guide Version 6.1: Psychoeducational services and ongoing support to maintain employment services are provided only if the services are not available through the federally funded Rehabilitation Act program administered by DES-RSA, which is required to be the primary payer for Title XIX eligible persons. The T/RBHA must monitor the proper provision of this service.

Employment Services

☐**On-site Supported Employment**
☐**Network Supported Employment**
☐Job Coaching/ Job Support
☐Job Preparation (resume/interview skills)
☐Unpaid/ Paid Work Activity

Provider:
☐Beacon ☐*Focus ☐*Lifewell
☐*MARC ☐REN ☐VALLEYLIFE ☐Wedco

* Location: ______________________________

When referring a member for employment related services a referral must also be made to RSA/VR.

Meaningful Activity

☐Psychosocial Rehabilitation (Clubhouse/Village)
☐Supported Volunteering
☐Supported Education
☐Consumer Operated Services

Provider:
☐*Cheeers ☐*Hope Lives ☐*Lifewell
☐*Marc ☐*PSA–Art Awakenings ☐*REN
☐*RI International ☐*STAR

* Location: ______________________________

☐Other service to engage in meaningful activity:

Information that may assist the member in obtaining the employment goal:

Unique Strengths:

Unique Needs/Challenges:

Referred to Vocational Rehabilitation (VR)? ☐Yes ☐No**
Date referred/referral packet to VR: ________________ **Packet provided to**: ____________________
Date of VR Information Session: ____________

If member was **not referred to VR program, please explain:
☐**Member's goal not job/work-related**.
☐**Member refused VR services** (documentation required in member clinical record).
☐**Member currently in VR program** **VR program staff**: ____________________
☐Other:

Clinical Team Action:
Does member have an **employment /vocational/rehabilitation goal** on the Individual Service Plan (ISP)?
☐Yes **List current goal:** ____
☐No* *If no, please update the ISP. Clinical documents must be current and reflect member's service need.*
☐Completed **DB101 – Benefits Planning** with the member.

Referral packet needs to be submitted to Provider/RSA/VR Counselor within seven (7) business days:

____
Rehabilitation Specialist/Case Manager **Date**

A copy must be included in a referral packet for: Network Employment/Rehabilitation Services and/or RSA/VR.
File original in member medical record. Revised 7/1/2018