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PATHWAYS TO RESILIENCE

ADULT MENTAL HEALTH INTENSIVE OUTPATIENT PROGRAM

REFERRAL FORM

1. MEMBER INFORMATION

Name _____

DOB _____ **Phone** _____ **Preferred contact method** _____

AHCCCS ID _____ **Health Plan** _____

2. REFERRAL INFORMATION

Referral date _____ **Referring provider/program** _____

Contact name _____ **Phone/email** _____

3. REASON FOR REFERRAL

Briefly describe why IOP services are being requested:

Known behavioral health diagnosis(es), if available: _____

4. IOP SCHEDULE, LOCATION, AND SUPPORTING INFORMATION

Program format: **IN-PERSON GROUP ONLY**

Program schedule: Monday, Wednesday & Friday, 10:00 a.m.-1:00 p.m.

Make-up group: Thursday, 10:00 a.m.-1:00 p.m., when needed

Preferred location: ☐ Cobblestone ☐ Speedway ☐ Either site ☐ Discuss with member

Able to participate in group-based treatment? ☐ Yes ☐ No ☐ Unsure

Known barrier to attending the IOP schedule? ☐ No ☐ Yes _____

Current clinician/provider, if applicable _____

Supporting documents (external referrals only, if available):

☐ Assessment ☐ Treatment Plan ☐ LOCUS ☐ Discharge Summary ☐ Medication List

Internal referrals: attachments are not required. ☐ Other _____

Other information important for IOP screening:

Submitted by _____ **Date** _____

SEND COMPLETED REFERRALS TO: Adult.MH.IOP@codac.org

The receiving team will aim to acknowledge the referral and provide an initial status update within 7 calendar days of receipt.

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INSTRUCTIONS FOR COMPLETING THE IOP REFERRAL FORM

Purpose

Use this form to request screening for the Pathways to Resilience Adult Mental Health Intensive Outpatient Program (IOP). The referral initiates screening and does not determine IOP eligibility or medical necessity. It does not replace the comprehensive assessment or assessment update, LOCUS, applicable clinical screeners, service plan update, health-plan review, or authorization process.

1. Member Information

Enter the member's legal name, date of birth, current phone number, AHCCCS identification number, and health plan. Include the preferred contact method when known.

2. Referral Information

Enter the referral date, referring provider or program, and the name and secure contact information of the person the IOP team may contact for clarification or care coordination.

3. Reason for Referral

Briefly explain why an evaluation for IOP is being requested. Focus on current mental health symptoms, functional difficulties, recent changes, need for more structure than routine outpatient care, or step-down needs. List known behavioral health diagnoses if available. The referring person is not responsible for determining IOP medical necessity or final level of care.

4. Program Format, Schedule, and Location

Explain that Pathways to Resilience is an in-person, group-based Mental Health IOP. Core groups are Monday, Wednesday, and Friday from 10:00 a.m.-1:00 p.m. The Thursday group is from 10:00 a.m.-1:00 p.m. and is used for make-up group when needed; it is not a required fourth treatment day for every member. Select Cobblestone, Speedway, Either site, or Discuss with member. Identify known barriers such as schedule conflicts, transportation, communication access, caregiving responsibilities, or other attendance concerns.

Supporting Records

Internal referrals: Supporting records do not need to be attached when the information is available in the member's clinical record. External referrals: Submit available relevant supporting records securely with the referral. These may include a recent assessment, treatment plan, LOCUS, discharge summary, or medication list. Do not delay the referral solely because a record is unavailable.

Submission and Follow-up

Complete the submitted-by and date fields. Send the completed referral securely to Adult.MH.IOP@codac.org. The receiving team will aim to acknowledge the referral and provide an initial status update within 7 calendar days of receipt. If additional information is needed or review remains pending, the referral source will be notified of next steps. The receiving IOP team will complete the applicable assessment and level-of-care review and address site availability and payer requirements.

Crisis Disclaimer

This referral is intended for members being considered for routine IOP admission. Members requiring immediate crisis intervention, emergency evaluation, or a higher level of care should be referred to the appropriate service rather than through the routine IOP referral process.

Keep completed forms and supporting records within approved privacy and records-management systems.

Referral initiates screening and does not establish IOP eligibility or medical necessity.