

STAR East

STAR Central

STAR West

Stand Together and Recover Inc. (STAR) Consumer's Name: _____
2144 East Roosevelt
Phoenix, Arizona 85006 Date of Birth: _____
602/231-0071 602/231-0334 FAX

STAR REFERRAL REQUEST FORM
(formerly SELFF and SOON)

Service Recipients who either refer themselves to STAR or are referred by Magellan clinics or other providers must submit a STAR Referral Request Form. The STAR Referral Request Form must be approved by STAR administration prior to the member's attendance. It is therefore the responsibility of the provider staff (case manager, etc.) that refers service recipients to submit this completed Request Form to STAR.

The STAR Referral Request Form must be forwarded to STAR in advance and approved by STAR prior to the service recipient's attendance, and must include the following items:

- 1) *This request, with required signatures.*
- 2) *Current service recipient's ISP and EA1013.*
- 3) *Does the service recipient have AHCCCS coverage including behavioral health benefits?*
Please mark appropriate box below:

Yes

No

Does the service recipient have any SOCIAL BEHAVIORS that may require additional attention from STAR staff? Yes No

If yes, please explain: _____

I verify that this service recipient's attendance at STAR is part of his/her current ISP.

Case Manager's Signature

Date

Sign here only if the check box under line 3 is marked "Yes."

I verify that _____ is Title XIX eligible.

Case Manager's Signature

Date