ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

DDD BEHAVIORAL HEALTH ADVOCATE REFERRAL

INSTRUCTIONS

To refer a member to DDD's Behavioral Health Advocacy program, complete all applicable sections of this referral form and email it to the BH Advocate Email Box: OIFABHAdvocate@azdes.gov. Identify the subject line as: BH Advocate Referral for (Member's Initials). (Refer to the DDD Behavioral Health Advocacy procedure for more details.)

SECTION I. MEMBER INFORMATION

Member Name *(Last, First, M.I.)*: _____ Date: _____

Date of Birth: _____ Primary Language: _____ Area Code and Phone No.: _____

Email Address: _____ Preferred Time to Contact: _____

Member Health Plan: _____

Responsible Person Name: _____

Email Address: _____ Area Code and Phone No.: _____

Relationship to Member: _____ Preferred Time to Contact: _____

Does member have a: ☐ Public Fiduciary ☐ Court-Appointed Guardian
☐ Behavioral Health Human Rights Advocate assigned by the Special Assistance Program

If yes, Name: _____ Area Code and Phone No.: _____

Support Coordinator Name: _____ District: _____

Email Address: _____ Area Code and Phone No.: _____

Support Coordinator's Supervisor Name: _____

Email Address: _____ Area Code and Phone No.: _____

Behavioral Health Complex Care Specialist Name, If assigned: _____

Email Address: _____ Area Code and Phone No.: _____

Behavioral Health Agency, If assigned: _____

Behavioral Health Agency Contact Name: _____

Email Address: _____ Area Code and Phone No.: _____

Has the member or responsible person agreed to accept the assistance of an Advocate? ☐ Yes ☐ No

See page 2 for EOE/ADA disclosures

SECTION II. REASON FOR REFERRAL

Check all applicable concern factors. In the Reason for Referral text box provide sufficient details needed to understand all of the concern factors checked. Also, include information regarding the barriers to resolve the issue(s) and actions taken, such as contacts made with DDD function areas, the Health Plan, and providers to resolve the issue(s).

- ☐ Feels her/his voice is not being heard or her/his choice is not being respected regarding their behavioral health service needs.
- ☐ Feels she/he is not actively involved in the service planning process.
- ☐ Has limitations in the ability to communicate her/his behavioral health needs.
- ☐ Is unable or does not know how to advocate for her/himself and would benefit from advocacy services.
- ☐ May need assistance in navigating the behavioral health or other service systems of care.
- ☐ May need assistance in understanding the behavioral health grievance process.
- ☐ Other: _____

Reason for Referral: