

TARGETED INVESMENT PROGRAM (TIP) REFERRAL FORM

Send referral and signed ROI (if applicable) via email to: TIP@terroshealth.org (please complete form with as much information as you have available for client)

Date:	Client Name:			DOB:	
Phone:	Add	dress:			
Incarceration Status	s: Currently Incarcerated (whi	h jail?) 			Not Incarcerated
AHCCCS ID (If availa	ble):	Healt	th Plan:		
AHCCCS Status (plea	se choose one) Active Suspende	d Eligible No	ot Active	Not Sure	
Reason for Referral (check ALL that apply):				
Primary Care/i Substance Use Medication As Peer Support/C Other (Please of Preferred Appointment 27th Avenue : 3	sisted Treatment (MAT) Community Resources Needed	AM PM No Pr	reference	<u>Date:</u>	
			and walk-ii	ns accepts for Pr	imary Care,
PROBATION OFFICER	<u> </u>	CHECK IN SITE (e	ex: WRC, Bo	CB, PSC):	
OST/FROST:		RELEASE DATE:			
PROBATION OFFICE	R CONTACT INFO:				
BRIEF DESCRIPTION	OF TRANSITIONAL NEEDS (if applica	ble):			
DISPOSITION (For Te	rros Health Use Only):				
☐ Referral Accepted☐ Referral Declined	d. Reason: needs do not fit service	s offered, out of	service are	ea	