SOAR Referral Form

Date: \_\_\_\_\_\_\_\_\_\_

# Referral Information

1. To refer a participant to the SOAR Benefit Specialist, please complete this referral and return the form to: Pamela Ramirez and/or Jayne Klages Fax: 602-712-9222 or email the form to: [pamelar@azabc.org](mailto:pamelar@azabc.org) or jaynek@azabc.org
2. Once the referral has been reviewed, we will notify the participant and the clinical team. We will begin the process of engaging with the participant and applying for benefits.
3. If you have any addition questions, please contact: Pamela Ramirez at 602-712-9200 x 220 or Jayne Klages at 602-712-9200 x 207

# Participants Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participants Name: | |  | Date of Birth: |  |
| Address: | |  | Social Security Number: |  |
|  |  |
| Email: |  | | Telephone: |  |
| Best time to contact: |  | | Message phone: |  |

# Provider Information

|  |  |  |
| --- | --- | --- |
| Provider: | |  |
| Case Manager: | |  |
| Email: |  | |
| Telephone: |  | |
|  |  | |
| \***Please share any additional information that would assist us in engaging with the participant:** |  | |
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