SUNWEST LTC PHARMACY

1300 N. 12th Street, Suite 406
Phoenix,AZ 85006
Tel. (602) 396-7330 Fax (602) 688-8016
email:ltc@sunwestrx.com

ENROLLMENT FORM

Please print. Thank you for choosing Sunwest LTC Pharmacy.

PERSONAL INFORMATION

Name: ____________________

Address: ____________________

City: ____________ State: ____________ Zip Code: ____________

Home Phone: ( ) ____________ Other Phone: ( ) ____________

Social Security #: ____________ Date of Birth: ____ / ____ / ____ Sex: ______

INSURANCE INFORMATION

Medicare #: ____________ Payee Contact Info: ____________

Primary or Secondary Insurance (please circle one): ____________

Insurance Phone #: ( ) ____________ Policy or ID #: ____________ Group #: ____________

Name of Policyholder (if not patient): ____________ ____________

Policyholder's Date of Birth: ____ / ____ / ____ Policyholder's SS#: ____________

City: ____________ State: ____________ Zip Code: ____________

MEDICAL INFORMATION

Physician's Name: ____________________

Address: ____________________

City: ____________ State: ____________ Zip Code: ____________

Allergies: ____________________

Current Pharmacy Name: ____________ Phone: ( ) ____________

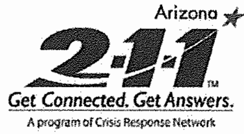
RX# / Med Name: ____________ RX# / Med Name: ____________

RX# / Med Name: ____________ RX# / Med Name: ____________

RX# / Med Name: ____________ RX# / Med Name: ____________

(If additional space is needed please provide on separate sheet)

Facility Name: ____________ Phone: ( ) ____________



COMMUNITY INFORMATION AND REFERRAL SERVICES
MARICOPA HMIS PROJECT

CLIENT ACKNOWLEDGEMENT OF DATA ENTRY
INTO THE MARICOPA HOMELESS MANAGEMENT INFORMATION SYSTEM

The Maricopa Homeless Management Information System (HMIS) is used by homeless provider agencies to record information about clients that they *serve.* This information helps the agencies to plan for and provide services to clients.

By signing this document you:

- Acknowledge that demographic information about you and your family will be entered into the Maricopa Homeless Management Information System (HMIS) database.
- All information entered by this project will automatically be locked and protected for your security and privacy. Understand that no information entered about you In HMIS will be shared without your specific written approval.

______________________________	______________________________
Client's Signature	Other Party (If client is minor or otherwise requires guardian)
______________________________	______________________________
Date Signed	Relationship to Client

DCS Stabilization Services

☐ **SW Region** ☒ **Central Region**

DCS Staff Email form to: +D-1 DCS Stabilization

Stabilization Teams do not go into Detention, ADJC Facility, Jails, Prisons, RTC's or Psychiatric Hospitals

Date of Request: ______ Requesting agency StreetLightUSA Staff name: ______________

CLIENT INFORMATION

CHILDS Case ID#:	Child's SSN:	Ethnicity: Choose an item.
Last Name: First Name: MI:	☐ Male ☐ Female DOB: / /	AHCCCS ID:
Name of Placement: STREETLIGHTUSA		
Name of Placement Contact: ANAINI MARTINEZ		
Phone: 623-866-7718	Cross Streets: 81ST AVE AND GLENDALE AVE	
Address: 6805 N. 81st Ave	City: GLENDALE	Zip Code: 85303
Interpreter Needs (Y/N): No	Language: Choose an item.	

DCS/GUARDIAN INFORMATION

DCS Case Manager:		Email:
DCS Supervisor:		Email:
DCS Office Address:		
Phone:	Ext:	Fax:

PROVIDER NETWORK ORGANIZATION/QUALIFIED SERVICE PROVIDER

Which PNO/QSP/CFT is involved with the child?		Date of next CFT:
PNO Primary Contact Name:		
Phone:	Ext:	Email:
QSP Primary Contact Name:		
Phone:	Ext:	Email:
Has the child previously received DCS Stabilization Services? If yes, Date __/__/____ with ☐ Empact ☐ Terros		

REFERRAL INFORMATION (Please check all that apply)

☐ History of Disruption ☐ Current risk of disruption in placement ☐ Behaviors posing a Danger to Self of Danger to Others ☐ Approved and awaiting a higher level of care	☐ Multiple crisis incidents in previous 3-6 months ☐ Child being stepped down from higher level of care ☐ Other (please describe below)
Please briefly explain your reason for the referral and/or what you would like CPS Stabilization Team to set for goals. What behaviors do you want the Team to work on?	

CRN USE ONLY:

SharePoint: _____ CIS: ______________________ T19 / T21: _____ Enrolled: _____ Provider: ____________

AHCCCS ID: ______________________ Health Plan: ____________

ASU College of Nursing & Health Innovation
ARIZONA STATE UNIVERSITY

ASSENT FORM

Streetlight USA: Aerobic Exercise for Health and Well-Being

We, at Arizona State University College of Nursing and Health Innovation and the College of Health Solutions, are trying to learn more about how to help teens improve their health and well-being.

You will be asked to participate in a 12-week exercise program. The program will offer one-hour classes, three times per week, of high intensity interval training (HIIT), Zumba, Pilates, dance, and other aerobic activities.

You will also be asked to fill out a few surveys (a written set of questions) before, during, and after the exercise program. The surveys will ask you about your self-worth, sleep patterns, eating habits, and physical activity outside of the exercise program. The surveys may take you up to a half hour to complete. If you don't want to answer a question, it is ok to leave the answer blank. We will also be viewing your intake forms that were filled out when you came to Streetlight USA. We will only collect information about your age, race/ethnicity, height, weight, how long you have been living at StreetLightUSA, and the last grade you completed.

Personal care items such as shampoo, conditioner and makeup (Value = $5.00) will be given to you after you complete the study. It will not cost you anything to help with this study.

You do not have to be in this study. No one will be mad at you if you decide not to join in. You may still attend the aerobic classes without participating in the study. Even if you start the study, you can stop later if you want. Your stay at Streetlight USA will not be affected if you decide not to join in the study. You may ask questions about the study at any time.

You will be given an identification number when you start the study so that your name will not appear on the surveys. We will not tell anyone else how you answer the questions on the surveys.

If you sign this form, it means that you have read this form and are willing to be in this study. If you have questions about being in this study or if you feel you have been placed at risk, you can contact the Chair of the Human Subject Institutional Review Board, through the ASU Research Compliance Office, at 480-965-6788.

If you do not want to be in the study, do not sign the form.

If you want to participate in the study, please sign below:

Signature ______________________________________

Printed first and last name ____________________________

____initials 1

Date ____________________________

Witness____Date__________________________

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Dream – Discover – Deliver