TRI·CITY
Mental Health Services

Children's ages (0-15)
Referral and Authorization form for
Full Service Partnership Services

NOTE: *This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Instructions Code, Civil Code and HIPPA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.*

REFERRAL INFORMATION

Date: …… Preferred Language: ……

First Name: ……..…… Last Name: ……..…

DOB: ……..… SSN: ……..… Race/Ethnicity: …….

Gender: Female Male

Address: …… City: …… ZIP Code: …….

Phone Numbers: …….. Current Living Arrangement: ……

Insurance: M/Cal…… Healthy Families ……. Healthy Kids …….. Private …… None …….

Primary Contact: _____, Relationship to Consumer: _____.

Address: _____ Phone: _____.

Preferred Language: _____

Conservator? ☐ Yes ☐ No Whom? _____ .

REFERRAL SOURCE

Referral Agency/Source: _____ Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Is consumer currently receiving services from referral agency? ☐ Yes ☐ No

Other Agencies Involvement: DCFS probation DMH Regional Center

Was the FSP brochure given to the referral source? ☐ Yes ☐ No

If consumer was referred to any other programs, please identify_____
_____
_____
_____

TRI·CITY Mental Health Services

Consumer's Name: _____

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FOCAL POPULATION

Check appropriate reasons for referral of a child with SERIOUS EMOTIONAL DISTURBANCE*

1- Zero to five year old (0-5) who:
- ☐Is at risk of expulsion from pre-school
- ☐Is involved with or at high risk of being detained by Department of Children and Family Services
- ☐Has a parent/caregiver with SED or severe and persistent mental illness, or who has substance abuse disorder or co-occurring disorders

2- Child/youth who:
- ☐Has been removed or is at risk of removal from their home by DCFS
- ☐Is in transition to a less restrictive placement

3- Child/youth who is experiencing the following at school:
- ☐Suspension or expulsion
- ☐Multiple Disciplinary Academic/Behavioral Referrals
- ☐Violent behaviors
- ☐Drug possession or use
- ☐Suicidal and/or homicidal ideation

4- Child/youth who:
- ☐Is involved with probation, is on psychotropic medication, and is transitioning back into a less structured home/community setting

Provide detail for any checked item: _____
_____
_____
_____
_____

*"Seriously emotionally disturbed" means minors under the age of 18 who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
(i) The child is at risk of removal from home or has already been removed from home.
(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. (California Welfare and Institutions Code Section 5600.3)

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Consumer's Name: _____

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LEVEL OF SERVICE

CHECK ONE ONLY:

☐UNSERVED (Not receiving mental health services)

☐Underserved (Receiving some mental health services, though insufficient to achieve desired outcomes)*

☐Inappropriately served (Receiving some mental health services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the consumer)*

*If consumer has received community based mental health services within the last 6 months, 1) identify the programs; 2) indicate the type and frequency of services; and 3) explain why the services are insufficient/ inappropriate to achieve desired outcomes:

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATION

Primary DSM-IV-TR Diagnosis: _____

Dual Diagnosis (X Code): _____

Check all that applies to individual:

Aggressive Ideation
Inappropriate Sexual Ideation
Aggressive Act (by history or current)
Aggressive Threats (by history or current)
Fire Setting or Acts
Inappropriate Sexual Acts
Tarasoff Notifications (past or current)
Suicidal Ideation/Attempts
Other

Provide Detail for Any Checked Items: _____

_____

_____

_____

Fax completed forms to Tri-City Mental Health Center Director of Clinical Program Services:
Attention: Antonette Navarro (909) 623-8552

TRI·CITY Mental Health Services

Consumer's Name: _____

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DISPOSITION

Date received: _____

☐Not authorized for Enrollment (Explain reasons for decision and plan for linkage to other services):

_____

_____

☐Authorized for Enrollment:

Program Supervisor:_____ Phone: _____

Assigned Clinician: _____ Phone: _____

City: _____

☐ Not authorized for Contract-out FSP Service (Explain reason for decision and plan for linkage to other community services: _____

_____

_____

☐ Authorized for Contract-out FSP Services.

Name of FSP Agency:

FSP Program Address: _____ City _____

ZIP Code: _____

Contact Person: _____ Phone: _____

City: _____ Service Area: _____ Fax Number: _____

To be completed by FSP agency

Please **Fax** completed Referral and Authorization Form to Tri-City Mental Health Center MHSA Manager

☐ Agency declines to enroll, but individual is eligible for FSP (Must complete Appeal Form)
☐ Individual does not agree to services (explain reasons for decision and plan for linkages)
☐ Individual is deemed ineligible for FSP Services (explain reasons and plan for linkages)

_____

_____

_____

FSP Agency Representative: _____ Date: _____