TRI·CITY Mental Health Services

Adults (Ages 60+)
Referral and Authorization form for
FULL SERVICE PARTNERSHIP

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 ☐ M/Care ☐ V.A. ☐ 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: ☐ Parole ☐ Probation ☐ APD ☐ GR/DPSS

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 reason(s) for referral:

	# Episodes in Last 12 months
☐ Homeless	_____
☐ Jail	_____
☐ Hospitalization (acute psychiatric inpatient)	_____
☐ At imminent risk of homelessness (e.g. at risk of eviction due to code violations)	_____
☐ Risk of going to jail (e.g. multiple interactions with law enforcement over 6 months or more)	_____
☐ Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home	_____

☐ Being released from SNF/Nursing Home (Facility name_____)

☐ Presence of a Co-occurring Disorder

- ☐ Substance Abuse
- ☐ Developmental Disorder
- ☐ Medical Disorder
- ☐ Cognitive Disorder

☐ Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated (e.g. APS – referred clients)

☐ Serious risk of suicide (not imminent)

☐ Current enrollment in an ACT/AB2034 program and is aging up in the system

Provide detail for any checked item:

_____

_____

_____

_____

_____

TRI·CITY Mental Health Services

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 Ideation or Acts
☐Inappropriate Sexual Ideation or 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: (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 Referral to Contract-out FSP Agency (Explain reason for decision and plan for linkage to other community services: _____

_____

_____

☐ Authorized for Referral to Contract-out FSP Agency.

Name of FSP Agency:

FSP Program Address: _____ City _____

ZIP Code: _____

Contact Person: _____ Phone: _____

Fax Number: _____

Authorizing Representative: _____ Date: _____

FSP Agency Notified Date: _____

To be completed by FSP agency

Please **Fax** completed Referral and Authorization Form to Tri-City Mental Health Center Clinical Director

☐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: _____