



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 HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom 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:



Consumer's Name: \_\_\_\_\_

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### FOCAL POPULATION

**Check appropriate reason(s) for referral:**

- |  | # Episodes in<br>Last 12 months |
|--|---------------------------------|
| <input type="checkbox"/> Homeless  | _____                           |
| <input type="checkbox"/> Jail  | _____                           |
| <input type="checkbox"/> Hospitalization (acute psychiatric inpatient)   | _____                           |
| <input type="checkbox"/> At imminent risk of homelessness<br>(e.g. at risk of eviction due to code violations)   | _____                           |
| <input type="checkbox"/> Risk of going to jail<br>(e.g. multiple interactions with law enforcement over 6 months or more)                                  | _____                           |
| <input type="checkbox"/> Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home   | _____                           |
| <input type="checkbox"/> Being released from SNF/Nursing Home (Facility name: _____ )  |                                 |
| <input type="checkbox"/> Presence of a Co-occurring Disorder   |                                 |
| <input type="checkbox"/> Substance Abuse   |                                 |
| <input type="checkbox"/> Developmental Disorder  |                                 |
| <input type="checkbox"/> Medical Disorder  |                                 |
| <input type="checkbox"/> Cognitive Disorder  |                                 |
| <input type="checkbox"/> Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated<br>(e.g. APS – referred clients) |                                 |
| <input type="checkbox"/> Serious risk of suicide (not imminent)  |                                 |
| <input type="checkbox"/> Current enrollment in an ACT/AB2034 program and is aging up in the system   |                                 |

Provide detail for any checked item:

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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:

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### DIAGNOSTIC CONSIDERATION

Primary DSM V 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: \_\_\_\_\_

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



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: \_\_\_\_\_