Clear Form

TRI·CITY Mental Health Services

Transition Age Youth (TAY ages 16-25)
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 HIPAA 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

**Transitioning Age Youth must have a serious Emotional Disturbance (SED)*
And/or Severe and Persistent Mental Illness (SPMI)****

☐ 1. Homeless or currently at risk of homelessness (indicate current living situation):

☐ 2. Youth aging out of:

- ☐ Child Mental Health System
- ☐ Child Welfare System
- ☐ Juvenile Justice System

☐ 3. Youth leaving Long-term Institutional Care

- ☐ Level 12-14 Group Homes
- ☐ Community Treatment Facility (CTF)
- ☐ Institution of Mental Disease (IMD)
- ☐ State Hospital
- ☐ Probation Camps

Estimated Discharge Date: _____

☐ 4. Youth experiencing their first psychotic break

☐ 5. Co-occurring Substance Abuse Disorder **in addition** to meeting at least one (checked) TAY focal population criteria identified above.

☐ 6. Living with family members without those support the individual should be at Imminent Risk of Homelessness, Jail or Institutionalization.

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)

**(SPMI) For TAY ages 16-25 may include significant functional impairment in one or more major areas of functioning (e.g., interpersonal relations, emotional, vocational, educational, or self-care) for at least 6 months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

Click to Submit

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 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 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:
(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: _____

City: _____ 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: _____