Wellness for Seniors

Referral and Authorization Form
Field Capable Clinical Services (FCCS)
Older Adults 60+

REFERRAL INFORMATION

Date:……..……

Last Name:…….. First Name: ……...…..…….

Social Security #: ……..…… Gender: ( ) M ( ) F

DOB: …..…….. Race/Ethnicity:……..……...… Preferred Language:…….

Address: …… City: …….. Zip: ……..…..….

Phone: ( ) ……..…… Current living situation: …..……...……..……...…..…

Insurance: ( ) Medi-Cal ( ) Medi-Care ( ) V.A. ( ) Other ……. ( ) None

Primary Contact: …… Relationship: ……..……

Preferred Language: ……..……. Phone: ( )……....

CONSERVATOR: ( ) YES ( ) NO IF YES, WHOM? : …….....

REFERRAL SOURCE

Agency: ……. Contact Person: ……..……

Phone: ( ) ……. Fax: ( ) ……..…….. Email: …….....

Individual currently receiving services, either within or outside your agency?: ○ YES ○NO

If yes, please identify:…….

Other Agency Involvement? ( ) HMO ( ) Adult Protective Services ( ) GR/DPSS ( ) Office of Aging

Has individual been referred to any other programs, please identify: ……..…….

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.

ELIGIBILITY GUIDELINES INFORMATION

A. Individual is age 60 or older? ___ Yes ___ No (If individual is not 60+, please specify age: ___)

B. Check one of the following:

- ◯ Individual has a serious or persistent emotional concerns for which they are currently being treated Or who has previously been treated.
- ◯ Individual has symptoms that are not severe or persistent but is accompanied by a functional impairment in activities of daily living or instrumental activities of daily living.
- ◯ Individual is at risk of losing or not attaining stable or safe living arrangements, risk of losing or inability to access needed services (including caregiver services), risk or losing independence due to current concerns or emotional impairments.

Provide details for any checked items:

_____
_____
_____
_____

C. CHECK ONE OF THE FOLLOWING:

- ◯ Other senior service agencies have been contacted/ indentified, but are not available to provide appropriate/ relevant services to this individual
- ◯ Individual cannot otherwise be appropriately served by another senior service agency

Provide details for any checked items:

_____
_____
_____
_____

SPECIFIC REASON FOR REFERRAL

Referrals with Dementia are not able to benefit from this program and are better referred to their MD or a Neurologist

A. Current Symptoms:

Please check all that apply:

◯ Depressed Mood	◯ Suicidal thought/comments	◯ Anxious mood
◯ Suspicious of others	◯ Aggressive thoughts/behavior	◯ Strange/unusual behavior
◯ Inappropriate sexual acts		◯ Recent or past traumatic event

Please explain any checked items:

_____
_____
_____

SPECIFIC RESON FOR REFERRAL CONTINUED

B. Other Related / Relevant Issues of Concern:

Please check all that apply:

- ◯ Isolated / Homebound
- ◯ History / risk of abuse or neglect
- ◯ Substance / Alcohol Abuse
- ◯ Medical problems / conditions

Please explain any checked items:

_____
_____
_____
_____
_____

Fax completed forms to Tri-City Mental Health Center Director Clinical Program Services:

Fax: (909) 623-8552
Phone: (909) 623-6131

DISPOSITION

To be completed by Tri-City Mental Health Center FCCS Agency

Date received: ……

○ Authorized for Enrollment:

Program Supervisor: _____ Phone: _____

Assigned Clinician: _____ Phone: _____

Authorizing Representative: _____ Date: _____

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

_____
_____
_____
_____
_____

○ Individual does not agree to services (explain reason for decision and plan for linkages)

_____
_____
_____
_____
_____

Date: _____

Authorizing Representative: _____