



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 HMO
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? 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 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.

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 of 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/ identified, 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Suicidal thought/comments | <input type="checkbox"/> Anxious mood |
| <input type="checkbox"/> Suspicious of others | <input type="checkbox"/> Aggressive thoughts/behavior | <input type="checkbox"/> Strange/unusual behavior |
| <input type="checkbox"/> Inappropriate sexual acts | | <input type="checkbox"/> Recent or past traumatic event |

Please explain any checked items:

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SPECIFIC REASON 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

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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: _____

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