TRI·CITY Mental Health Services

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

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

DMH IBHIS#: _____
Date: _____ Gender: ☐ Female ☐ Male ☐ Unknown SSN: _____
Last Name: _____ First Name: _____
DOB: _____ AGE: _____ Race/Ethnicity: _____
Preferred Language: _____ Phone: _____ Current Living Arrangement: _____
Address: _____ City: _____ ZIP Code: _____

Insurance: ☐ None ☐ MEDICARE ☐ MEDI-CAL ☐ Medi-Medi ☐ LA Care ☐ Beacon
☐ MHN (Managed Health Network) ☐ V.A. (Veterans Affairs) ☐ HealthNet ☐ HMO ☐ Private: _____

Benefits: ☐ GR Recipient (General Relief) ☐ V.A. (Veterans Affairs) ☐ SSI (Supplemental Security Income) ☐ SSDI (Social Security Disability Insurance) ☐ Other Income: _____

☐ Client Served in the Military

PRIMARY CONTACT: _____ RELATIONSHIP to Referred: _____ PRIMARY CONTACT PHONE: _____

CONSERVATOR?: ☐ Yes ☐ No NAME: _____ PHONE: _____

Is referral currently receiving any mental health services? ☐ Yes ☐ No

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer
☐ Questioning/Unsure ☐ Non-Binary ☐ Another Identity ☐ Unknown

Sexual Orientation: ☐ Heterosexual or Straight ☐ Gay or Lesbian ☐ Bisexual ☐ Unknown
☐ Queer ☐ Questioning/Unsure ☐ Another Sexual Orientation

Date Discussed with individual: _____

Reason for Referral to Field Capable Clinical Services (please check reason(s) for referral and explain in the space below):

☐ Impaired access to mental health services requiring field-based services ☐ Homeless/risk of homelessness

☐ Isolated/homebound/limited or no support system ☐ Multiple recent hospitalizations

☐ Transitioning from one level of care to another ☐ Recent release from jail or risk of incarceration

☐ Co-occurring disorders (mental, physical, substance, cognitive disorders)

REFERRAL SOURCE

Referral Agency: _____ Contact Person: _____ Phone: _____
Fax: _____ Email: _____

Is Individual currently receiving services, either within or outside your agency? ☐ Yes ☐ No

Other Agency Involvement: ☐ Probation ☐ Office of Aging ☐ Regional Center ☐ DMH (Department of Mental Health) ☐ GR (General Relief)/DPSS (Department of Public Social Services) ☐ APS (Adult Protective Services)

If individual was referred to any other programs, please identify: _____

☐ Family/Client is aware a FCCS referral is being made.
☐ Family/Client have been provided an FCCS brochure and have been informed of the FCCS referral.

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Consumers Name : _____

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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:

☐ 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:

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 Adult FSP Program (Adult/Older Adult/FCCS).
Fax: (909) 623-8552

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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: _____