Adults (Ages 60+)
Referral and Authorization form for
FULL SERVICE PARTNERSHIP

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REFERRAL INFORMATION

DMH IBHIS#: ______________

Date: ____________ Gender: ☐ Female ☐ Male ☐Unknown SSN: ______________

Last Name: ________________________________ First Name: ________________________________

DOB: ____________ AGE: ________

Race/Ethnicity: _________________________ Preferred Language: ____________________________

Address: ____________________________ City: ________________________ ZIP Code: _________

Phone: ____________________ Current Living Situation: ____________________________

Insurance: ☐ MEDI-CAL ☐ MEDICARE ☐ None ☐ Private: _______________________

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

☐ Client Served in the Military

PRIMARY CONTACT: ____________________________ RELATIONSHIP to Referred: ____________________________ PRIMARY CONTACT PHONE: ______________________

CONSERVATOR?: ☐ Yes ☐ No NAME: ___________________________ PHONE: ___________

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer ☐ Questioning/Unsure ☐ Another Identity ☐ Nonbinary ☐ Unknown

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

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REFERRAL SOURCE

Referral Agency: ____________________ Provider# (if applicable): _____________ Service Area: ________

Contact Person: ____ Phone: __________________

Fax: ____________________ Email: __________________

Is consumer currently receiving services from referral agency? ☐ Yes ☐ No

Other Agency Involvement: ☐ Probation ☐ Parole ☐ DMH (Department of Mental Health) ☐ Regional Center ☐ Adult Protective Services (APS) ☐ Agency for Persons with Disabilities (APD) ☐ GR (General Relief) / Department of Public Social Services (DPSS)

Was the FSP brochure given to the referral source? ☐ Yes ☐ No

If consumer was referred to any other programs, please identify:

____

☐ Family/Client is aware a FSP referral is being made.

☐ Family/Client have been provided an FSP brochure and have been informed of the FSP referral.

TRI·CITY Mental Health Services

Consumers Name : ___________________

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FOCAL POPULATION

CHECK APPROPRIATE REASON(S) FOR REFERRAL:

Reason	# Days during last 12 months
□ Homeless □ [1]Chronically Homeless (HUD Standards)	__________
□ Jail/Incarceration	__________
□ Hospitalization	__________
□ At imminent risk of homelessness (e.g. at risk of eviction due to code violations)	__________
□ Risk of going to jail (e.g. multiple interactions with law enforcement over 6 months or more)	__________
□ Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home	__________

□ Being release from SNF / Nursing Home Facility: ____

□ Presence of Co-occurring disorder:

□ Substance Abuse □ Developmental Disorder □ Medical Disorder □ Cognitive Disorder

□ Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated (e.g. APS – referred clients)

□ Serious risk of suicide (not imminent)

□ Current enrollment in an ACT/AB2034 program and is aging up in the system

Provide detail for any checked item:

____

Document any pertinent outreach information regarding client here: (Ex. Client is difficult to engage, client prefers female staff, language barriers, etc.)

____

CHECK APPROPRIATE REASON(S) FOR NOTIFICATION:

☐ At risk of out of home placement (Fall risk due to chronic health conditions and numerous medications, limited or no social and/or family support, etc.)

☐ At risk of becoming involved with the criminal justice system (Prior legal/incarceration history, Little or no family or social support, inadequate or no housing, etc.)

☐ At risk of being psychiatrically hospitalized (Suicidal ideation or attempts, Failure to coordinate and take both health and psychotropic medications as prescribed, limited or no connection to non-emergency community services, etc.)

Provide additional details:

____

____

____

[1] Chronic Homeless HUD: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has 4 episodes of homelessness in the past three years.

TRI·CITY Mental Health Services

Consumers Name : ________________

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LEVEL OF SERVICE

CHECK ONE ONLY: (See notation)

☐ UNSERVED (Not receiving mental health services)

☐ History of mental health services, but none currently*   ☐ No prior mental health services

☐ Underserved (Receiving some mental health services, though insufficient to achieve desired outcomes) *

☐ Recovery, Resilience & Reintegration Services   ☐ PEI   ☐ Other: ________________

☐ 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/appropriate to achieve desired outcomes

____
____
____

DIAGNOSTIC CONSIDERATION

Primary DSM V Diagnosis/ICD-10 Code: __________________________ Dual Diagnosis (X Code): __________

Check all that applies to individual:

☐ Aggressive Ideation

☐ Aggressive Acts (by history or current)

☐ Aggressive Threats (by history or current)

☐ Fire Setting Ideation or Acts

☐ Inappropriate Sexual Ideation

☐ Inappropriate Sexual Acts

☐ Psychiatric Hospitalizations (Indicate dates below)

☐ Suicidal Ideation/Attempts

☐ Symptoms of Psychosis

☐ Tarasoff Notifications (past or current)

☐ Other: ____

Provide Detail for Any Checked Items:

____
____
____

Consumers 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 Adult FSP Program (Adult/Older Adult/FCCS).

☐ 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)

Please include any additional information for checked off options above/plans for linkages:

FSP Agency Representative: ____________________________________ Date: _________________