TRI·CITY Mental Health Services

Adults (Ages 26-59)
Referral and Authorization form for
FULL SERVICE PARTNERSHIP

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: _____
Address: _____ City: _____ ZIP Code: _____
Phone: _____ Current Living Situation: _____

Insurance: ☐ MEDI-CAL ☐ MEDICARE ☐ None ☐ 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: _____

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

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

REFERRAL SOURCE

Referral Agency: _____ Provider# (if applicable): _____ Service Area: _____

Contact Person: _____ Phone: _____

Fax: _____ Email: _____

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

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

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

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

FSP Agency Representative: _____

☐ 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.

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Consumers Name : _____

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FOCAL POPULATION

CHECK APPROPRIATE REASON(S) FOR REFERRAL:

	# Days during last 12 months	# Episodes in last 12 months
☐ Homeless ☐ [1]Chronically Homeless (HUD Standards)		
☐ Jail		
☐ Institution(s) Type (Mark all that apply):		
☐ Institution for Mental Disease (IMD)		
☐ State Hospital		
☐ Psychiatric Emergency Services		
☐ Urgent Care Center		
☐ County Hospital		
☐ Fee for Service Hospital		

Name of Acute/Long Term Psychiatric Facilities: _____

☐ Living with family members without whose support the individual should be at Imminent Risk of Homelessness, Jail or Institutionalization - Specify:

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 becoming homeless (History of destruction of property, unable to maintain living arrangement, ongoing conflict with neighbors and/or landlord, etc.)

☐ At risk of becoming involved with the criminal justice system (Unable to pay fees, presence of warrants, two or more contacts with law enforcement in the past 90 days, etc.)

☐ At risk of being psychiatrically hospitalized (Two or more visits to a psychiatric urgent care center, medical emergency room for a psychiatric disorder, or psychiatric emergency room in the past 90 days or at least one encounter with an emergency outreach team in the past 90 days, 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.

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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/inappropriate 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:

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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 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: _____