



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 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.

REFERRAL INFORMATION

Date: Preferred Language:

First Name: Last Name:

DOB: SSN: Race/Ethnicity:

Gender: Female Male

Address: City: ZIP Code:

Phone Numbers: Current Living Arrangement:

Insurance: M/Cal M/Care V.A. Private None

Primary Contact: _____, Relationship to Consumer: _____.

Address: _____ Phone: _____.

Preferred Language: _____

Conservator? Yes No Whom?: _____

REFERRAL SOURCE

Referral Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Is consumer currently receiving services from referral agency? Yes No

Other Agencies Involvement: Parole Probation APD GR/DPSS

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

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

Consumer's Name: _____

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FOCAL POPULATION

Check appropriate reason(s) for referral:

	# Episodes in last 12 months
<input type="checkbox"/> Homeless	_____
<input type="checkbox"/> Jail	_____
<input type="checkbox"/> INSTITUTION TYPE (Mark all that apply):	
Acute/Long Term Psychiatric Facilities _____	_____
Name of Institution	
<input type="checkbox"/> Institution for Mental Disease (IMD)	_____
<input type="checkbox"/> State Hospital	_____
<input type="checkbox"/> Psychiatric Emergency Services	_____
<input type="checkbox"/> Urgent Care Center	_____
<input type="checkbox"/> County Hospital	_____
<input type="checkbox"/> Fee for Service Hospital	_____
<input type="checkbox"/> Living with family members without those support the individual should be at Imminent Risk of Homelessness, Jail or Institutionalization. Specify:	

Provide detail for any checked item:

Consumer's Name: _____

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LEVEL OF SERVICE

CHECK ONE ONLY: (See notation)

- UNSERVED (Not receiving mental health services)
- Underserved (Receiving some mental health services, though insufficient to achieve desired outcomes)*
- 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-IV-TR Diagnosis: _____

Dual Diagnosis (X Code): _____

Check all that applies to individual:

- Aggressive Ideation
- Inappropriate Sexual Ideation
- Aggressive Act (by history or current)
- Aggressive Threats (by history or current)
- Fire Setting Ideation or Acts
- Inappropriate Sexual Ideation or Acts
- Tarasoff Notifications (past or current)
- Suicidal Ideation/Attempts
- Other

Provide Detail for Any Checked Items: _____

Please **Fax** completed Referral and Authorization Form to Tri-City Mental Health Center MHSA Manager:
Attention: Rimmi Hundal (909) 623-4073



Consumer's 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: _____

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 MHSA Manager

- 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)

FSP Agency Representative: _____ Date: _____