



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

- Homeless \_\_\_\_\_
- Jail \_\_\_\_\_
- 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		

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:

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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: \_\_\_\_\_