Children's ages (0-15)
Referral and Authorization form for
Full Service Partnership Services

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REFERRAL INFORMATION

DMH IBHIS#: _______________
Date: _____________ Gender: ☐ Female ☐ Male ☐ Unknown SSN: _______________
Last Name: ____________________________________ First Name: ___________________________________
DOB: _____________ AGE: ________ Ethnicity: ____
Race/Ethnicity: ____________________________ Preferred Language: _______________________________

Address: _______________________________ City: ___________________________ ZIP Code: __________

Insurance: ☐ MEDI-CAL ☐ Healthy Families ☐ Healthy Kids ☐ NONE / Indigent ☐ Private / Third Party Payor: ________________________

Current Living Arrangement: ☐ Home of Parent ☐ Relative ☐ Foster Home ☐ Transient ☐ Other: __________________
☐ Group Home - Facility Name: _______________________ Level: ________

PRIMARY CONTACT: ________________________________ RELATIONSHIP to Consumer: ________________
Address: ________________________________ PRIMARY CONTACT PHONE: _________________________ Preferred Language: ____________________________

CONSERVATOR?: ☐ Yes ☐ No NAME: ______________________________ PHONE: ________________

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

REFERRAL SOURCE

Referral Agency/Source: _________________________ Contact Person: ________________________________
Phone: ____________________ Fax: ______________________ Email: ____________________________________

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

Other Agency Involvement: ☐ Probation ☐ START Team ☐ Regional Center ☐ School System ☐ Other: ________________
☐ DCFS (Department of Child and Family Services) ☐ DMH (Department of Mental Health)

Please identify recent referrals: ☐ D-Rate ☐ RCL 12 or above ☐ Wraparound ☐ Other: ______________
☐ ISFC (Intensive Services Foster Care)

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 reasons for referral of a child with SERIOUS EMOTIONAL DISTURBANCE (SED)*[1]

1. Zero to five year old (0-5) who:

- ☐ Is at risk of expulsion from pre-school
- ☐ Is involved with or at high risk of being detained by Department of Children and Family Services
- ☐ Is at risk of removal or has been removed from the home by the Department of Children and Family Services (DCFS)
- ☐ Has a parent/caregiver with SED or severe and persistent mental illness, or who has substance abuse disorder or co-occurring disorders

2. Child/Youth who:

- ☐ Has been removed or is at risk of removal from their home by DCFS
- ☐ Has had three or more DCFS placements within the past 24 months
- ☐ Has a history of drug possession or use
- ☐ Is in transition to a less restrictive placement
- ☐ Is at risk of or currently involved with the juvenile justice system
- ☐ Is at risk of commercial sexual exploitation
- ☐ Is currently a victim of commercial sexual exploitation

3. Child/Youth who is experiencing the following at school:

- ☐ Suspension or expulsion
- ☐ Multiple Disciplinary Academic/Behavioral Referrals
- ☐ Violent Behaviors
- ☐ Drug possession or use
- ☐ Suicidal and/or homicidal ideation
- ☐ Failing classes
- ☐ Truancy or sporadic attendance

4. Child/Youth unable to function in the home and/or community setting and:

- ☐ Is at risk of becoming or is currently homeless
- ☐ Is transitioning back to a less structured home or community setting*:

*Type of setting: ____ Estimated Discharge Date: ___________

Provide detail for any checked item:

____

____

[1] Seriously emotionally disturbed" means minors under the age of 18 who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
   - (i) The child is at risk of removal from home or has already been removed from home.
   - (ii) (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. (California Welfare and Institutions Code Section 5600.3)

Consumers Name : ___________________

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DCFS INFORMATION

DCFS Case: ☐ Adoption ☐ ER Case ☐ New Detention ☐ Voluntary Case

Assigned DCFS Office: ____

CSW Name: ______________________________ Phone: ______________ **Email:** ___________

SCSW Name: ______________________________ Phone: ______________ **Email:** ___________

If you are a DCFSD referring party, please attach the following documents:

☐ Consents (179) / Minute Order ☐ Court Report / Voluntary Case Report ☐ JV 220 (current) ☐ Placement History ☐ Child Profile Report

LEVEL OF SERVICE

CHECK ONE ONLY:

☐ UNSERVED (Not receiving mental health services)

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

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

☐ PEI ☐ Outpatient ☐ Other: ____

☐ Inappropriately served (Receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the consumer)*

If client is currently receiving mental health services please indicate:

Therapist: _________________________ Agency: __________________ Phone: ________________

*If client 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)
- ☐ Inappropriate Sexual Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Fire Setting Ideation or Acts
- ☐ Tarasoff Notifications (past or current)
- ☐ Suicidal Ideation/Attempts
- ☐ Contact with PMRT or Urgent Care
- ☐ Eating Disturbances
- ☐ Exposure to Trauma
- ☐ Hyperactive/Impulsive/Inattentive
- ☐ Psychiatric Hospitalizations (indicate dates below)
- ☐ Symptoms of Psychosis
- ☐ Emergent Medication Needs

☐ Other: ____

Provide Detail for Any Checked Items:

____

Fax completed forms to Tri-City Mental Health Center Childrens FSP Program (COP/TAY).
Fax: (909) 865-0730

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: ____

To be completed by FSP agency

Please **Fax** completed Referral and Authorization Form to Tri-City Mental Health Center Child FSP Program (COP/TAY).

☐ 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: _________________