TRI·CITY Mental Health Services

Transition Age Youth (TAY ages 16-25)
Referral and Authorization form for
Full Service Partnership Services

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

Date: _____ Gender ☐ Female ☐ Male ☐ Unknown DMH IBHIS#: _____ SSN: _____

Last Name: _____ First Name: _____

DOB: _____ AGE: _____

Race/Ethnicity: _____ Preferred Language: _____

Address: _____ City: _____ ZIP Code: _____

Current Living Arrangement: ☐ Parent ☐ Relative ☐ Foster Home ☐ Transient

☐ Transitioning to a lower level of care or Jail

Insurance : ☐ MEDI-CAL ☐ Healthy Families ☐ Healthy Kids ☐ 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: ☐ Yes ☐ No

PRIMARY CONTACT: _____ RELATIONSHIP to Client: _____

Address: _____ PRIMARY CONTACT PHONE: _____ Preferred Language: _____

CONSERVATOR?: ☐ Yes ☐ No NAME: _____ PHONE: _____

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

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

REFERRAL SOURCE

Referral Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ Email: _____

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

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

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

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☐ Child/Family is aware a referral has been submitted to an intensive mental health program - referral source informed the client/family that an FSP referral is being made.

☐ Family/individual 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

Transitioning Age Youth must have a Serious Emotional Disturbance (SED)*[1] And/or Severe and Persistent Mental Illness (SPMI)**[2]

☐ 1. Homeless or currently at risk of homelessness (indicate current living situation): _____

☐ 2. Youth aging out of:

☐ Child Mental Health System ☐ Child Welfare System ☐ Juvenile Justice System

☐ 3. Youth leaving Long-term Institutional Care

☐ Level 12-14 Group Homes ☐ Institution of Mental Disease (IMD) ☐ Probation Camps

☐ Community Treatment Facility (CTF) ☐ State Hospital ☐ Jail

Estimated Discharge Date: _____

☐ 4. Youth experiencing their first psychotic break

☐ 5. Co-occurring Substance Abuse Disorder **in addition** to meeting at least one (checked) TAY focal population criteria identified above.

☐ 6. Living with family members without those support the individual should be at Imminent Risk of Homelessness, Jail or Institutionalization.

Provide detail for any checked item:

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) ***

☐ Recovery, Resilience & Reintegration Services ☐ PEI ☐ 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 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

*[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) 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)

**[2] (SPMI) For TAY ages 16-25 may include significant functional impairment in one or more major areas of functioning (e.g., interpersonal relations, emotional, vocational, educational, or self-care) for at least 6 months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

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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:

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

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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: _____

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 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: _____