San Diego County HHSA Adult/Older Adult Behavioral Health Services
Strengths-Based Case Management (SBCM) and Assertive Community Treatment (ACT) Referral Form

Additional information may be requested to assess program eligibility. If you are unclear where to refer the person, please fax the above information to (619) 542-4969 or call (619) 692-8715.

REFERRAL BEING MADE TO STRENGTHS-BASED CASE MANAGEMENT (SBCM) PROGRAM/S

☐Central/N. Central County SBCM: (619) 692-8715; Fax:(619) 542-4969
☐CRF SBCM South: For the Northern part of South Region contact (619) 427-4661, Fax:(619) 426-7849; For the Southern Region part of South Region contact (619) 428-1000, Fax (619) 428-1091
☐East County SBCM: (619) 692-8715; Fax:(619) 542-4969
☐North County TAY SBCM: (760) 758-1092; Fax:(760) 758-8481
☐MHS Inc. SBCM North: (760) 432-9884; Fax: (760) 740-0641
☐Telecare AgeWise Older Adult SBCM: (619) 481-5200; Fax: (619) 481-5217

REFERRAL BEING MADE TO ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM/S

☐Telecare Pathway: (619) 683-3100; Fax: (619) 682-4037
☐CRF IMPACT: (619) 398-0355; Fax: (619) 398-0350
☐MHS Inc. Center Star ACT: (619) 521-1743; Fax: (619) 521-1896
☐Providence Catalyst ACT: (858) 300-0460; Fax: (858) 300-0461
☐Telecare Gateway: (619) 683-3100; Fax: (619) 682-4037
☐CRF Downtown IMPACT: (619) 398-2156; Fax: (619) 398-2168
☐MHS Inc. North Star ACT: (760) 432-9884; Fax: (760) 432-9953
☐CRF Senior IMPACT: (619) 977-3716;Fax: (619) 481-3075

REFERRING PARTY INFORMATION

Date of Referral: ____/____/____ Name of Person Making Referral: ____________________

Email of Referring Party, if available* : ____________________

Referring Agency:____________________ Address: ____________________

Phone:____________________ Fax: ____________________

*If choosing to communicate via email, please ensure compliance to Article 14 and confidentiality requirements. Email may be used between providers and referring parties as long as no client information is included unless encryption is used. This referral form should never be sent via email unless encrypted.

IDENTIFYING INFORMATION OF PERSON BEING REFERRED

Name:____________________ SS# (Last 4 ONLY): _________ DOB: ____/____/____ MIS#: ____________________

Aliases: ____________________Gender:____________________ Language of Preference: ____________________

Address: ____________________ Phone: ____________________

Has he/she ever been Homeless? ☐YES ☐NO Period of Homelessness: ____________________

Emergency Contact: ____________________ Relation: ____________________ Phone: ____________________

CLINICAL INFORMATION

Is Person Interested in Case Management? ☐YES ☐NO Provide Specific Reason(s) for Referral: ____________________

____

____

____

Current Problems, Barriers, Challenges, OR Problems When Person is Not Stable: ____________________

____

____

____

Mental Health Stage of Recovery: ☐Pre-Contemplation ☐Contemplation ☐Preparation ☐Action ☐Maintenance ☐Relapse

History of Mental Health Treatment: ____________________

____

____

Number of Psych Hospitalizations in the Last 2 Years: _________Reasons:____________________

Does Person Have Problematic Use of Substances? ☐YES ☐NO Date of Last Use: ____/____/____

Substance(s) of Choice: ____________________

Substance Use Stage of Recovery: ☐Pre-Contemplation ☐Contemplation ☐Preparation ☐Action ☐Maintenance ☐Relapse

History of Drug/Alcohol or Co-Occurring Treatment: ______________________________

____

____

Risk for Harm or Dangerous Propensities (e.g., Suicide Attempts, SI, HI, Command AH, Hx of Violence, Threats, Risky Behavior):

____

Current Impairments in Daily Functioning: ______________________________

____

Goals, Strengths, and Interests: ______________________________

____

DIAGNOSES

Axis I (Primary): ______________________________

Axis I (Secondary): ______________________________

Axis II: ______________________________

Axis III: ______________________________

____

Axis IV: ☐Primary Support ☐Social Environment ☐Educational ☐Occupational ☐Housing
☐Economic ☐Access to care ☐Legal system ☐Other________________

Axis V: Current: _______ Year High: _______

CURRENT MEDICAL ISSUES

____

____

Primary Care Physician: ______________________________ Phone: ____________________

CURRENT MEDICATIONS

____

____

Current Treating Psychiatrist: ______________________________ Phone: ____________________

LEGAL INFORMATION

Is Person Conserved? ☐YES ☐NO Name of Conservator: ______________________________ Phone: ____________________

Has Person been Incarcerated or Had Legal Issues? ☐YES ☐NO If yes, please explain:______________________________

____

Person is on… ☐Parole ☐Probation ☐N/A Parole/Probation Officer:_______ ______________ Phone: ____________________

Other Pertinent Legal Information or Restrictions: ______________________________

FINANCIAL / INSURANCE INFORMATION

Current Source of Income: ☐SSI ☐SSDI ☐SDI ☐WORK ☐NONE ☐Other:______________________________

Payee: ___________________________ Phone: ______________________________

Current Insurance Status: ☐Medi-Cal ☐Medicare ☐VA ☐Indigent

Medi-Cal #: _________________________ Medicare #: ___________________________

Private/Other Insurance Information: _________________________ Policy #: _________________ Phone: ____________________

Signature of Person Completing Referral: _________________________________ Date: ____/____/____

TO BE COMPLETED BY RECIPIENT OF REFERRAL

Received: ____/____/____ Logged By (Initials): _______ Staff Contacted Person On: ____/____/____ Contacted by (Initials): ______

Was person admitted? ☐YES ☐NO Disposition: ______________________________

Staff informed ____________________________ at referring agency of disposition on ____/____/____. Informed by (Initials): ______

Complete this page ONLY if referring to an ACT program

Inclusion and Priority Criteria for All San Diego County BHS-Funded ACT Programs

Name of person who is being referred:____

INCLUSION CRITERIA: **Please circle one:**			
1. Ages of **16-24** (*Catalyst*); **25-59** (*IMPACT, Center Star, North Star, and Telecare Pathway)* or **18+** (*Downtown IMPACT and Telecare Gateway*); **60+** (*Senior IMPACT*)	YES	NO	N/A
2. Person has diagnosis of a severe and persistent mental illness (SPMI); usual diagnoses are Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder. [Note: SED may apply for some Catalyst referrals.]	YES	NO	N/A
3. Person has severe impairment in daily living skills (significant difficulty in major life domains, such as work, school, and/or home life).	YES	NO	N/A
4. Less intensive case management and mental health services have been insufficient to meet needs.	YES	NO	N/A
5. For Center Star ONLY: Person has legal or criminal justice system involvement with criminal detention within the last year.	YES	NO	N/A
6. Person is a high utilizer of community mental health services (e.g., PERT, hospitals, crisis houses).	YES	NO	N/A
If any of the above are answered as "NO" (except #5), the person being referred is likely to be ineligible for Assertive Community Treatment (ACT) services.			
PRIORITY CRITERIA:			
1. Presence of a co-occurring substance use or serious medical disorder	YES	NO	N/A
2. (A) Currently homeless, or (B) at risk of homelessness, and/or (C) history of homelessness (please indicate which)	YES	NO	N/A
3. High risk of dangerous behavior (to self or others) based on history, not due to Antisocial Personality Disorder			
4. Current or former foster youth, if under age 25	YES	NO	N/A
5. Person has Medi-Cal or is indigent			
6. Legal or criminal justice system involvement	YES	NO	N/A
7. Repeat utilization of ER, EPU, IMD and/or acute inpatient care within the last year (indicate approximately how many episodes and days, if known)	YES	NO	N/A
8. Person belongs to a potentially underserved population (including Asian American, Latino, Asian Pacific Islander, Native American, African American, LGBTQ, pregnant or parenting mother)	YES	NO	N/A
9. Isolated, living alone, and/or without social support	YES	NO	N/A
Persons with highest number of "Yes" responses will generally be considered highest priority referrals. **TOTAL NUMBER OF YES RESPONSES:**			

General **EXCLUSION** criteria:

1. Sole or primary diagnosis of substance use disorder or developmental disability.
2. Person has diagnosis that does not support the criteria for Severe and Persistent Mental Illness (SPMI) (e.g., diagnosis is Antisocial Personality Disorder).
3. Person has not received or been offered less intensive mental health services.
4. Person's only otherwise unmet need is subsidized housing.
5. Person is currently on parole.

IMPORTANT: All referrals will be evaluated on the above criteria. Priority for services will be given to persons who have the most serious mental illness and the most intensive need for ACT level services ***at the time of an opening***. Please note that housing services or subsidies are not available as a stand-alone service in an ACT program.