

Augmented Services Program (ASP) Referral Checklist



COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

1. APPLICANT INFORMATION

Name (First and Last): _____

Date of Birth: _____

SmartCare Number: _____

CARE Client: ☐ Yes ☐ No

Step down from Mental Health Rehabilitation Center (MHRC) or State Psychiatric Hospital: ☐ Yes ☐ No

2. CASE MANAGEMENT (CM) INFORMATION

Case Management (CM) Provider: _____

CM Point of Contact: _____

CM Point of Contact Phone Number: _____

CM Point of Contact Email Address: _____

Representative Payee Contact: _____

Representative Payee Phone Number: _____

Comments: _____

3. SUBMISSION OF SUPPORTING DOCUMENTATION

Submission method for supporting documentation (client history, physical, TB test, etc.):

☐ Encrypted email ☐ Fax ☐ Other: _____

Submission date for supporting documentation: _____

Board & Care (B&C) ASP Facility submitted to: _____

Send completed document via encrypted e-mail to:

- HHSA, BHS-ASP BHS-ASP.HHSA@sdcounty.ca.gov
- Respective B&C Provider