County of San Diego HHSA Adult/Older Adult Behavioral Health Services

ASSERTIVE COMMUNITY TREATMENT (ACT) FOR HOMELESS PERSONS WITH SEVERE MENTAL ILLNESS REFERRAL FORM

*** Hover the pointer over the program title, right click the mouse and select "Open Hyperlink" for more information. ***

REFERRAL TO ASSERTIVE COMMUNITY TREATMENT (ACT) PROGRAMS

☐ Community Research Foundation South Bay IMPACT (South):	Phone (619) 934-5770; Fax (619) 391-0091 Email:SouthBayImpactReferrals@comresearch.org
☐ Community Research Foundation Downtown IMPACT (Central):	Phone (619) 398-2156; Fax (619) 398-2168 Email:DowntownImpactReferrals@comresearch.org
☐ Community Research Foundation IMPACT (Central/North Central):	Phone (619) 398-0355; Fax (619) 398-0350 Email:ImpactReferrals@comresearch.org
☐ Community Research Foundation Senior IMPACT (Countywide):	Phone (619) 977-3716; Fax (619) 481-3075 Email:SeniorImpactReferrals@comresearch.org
☐ Pathways Catalyst ACT (Countywide):	Phone (858) 300-0460; Fax (858) 300-0461 Email:PTW_CA_SAN2_CatalystReferrals@pathways.com
☐ TURN BHS Center Star ACT	Phone (619) 521-1743; Fax (619) 393-0242 Email:CenterStarACT.referrals@turnbhs.org
☐ TURN BHS City Star ACT	Phone (858) 609-8742; Fax (858) 292-0322 Email:CityStarACT.referrals@turnbhs.org
☐ TURN BHS North Coastal ACT	Phone (760) 290-8170; Fax (760) 439-0019 Email:NorthCoastalACT.referrals@turnbhs.org
☐ TURN BHS North Star ACT	Phone (760) 432-9884; (760) 432-9953 Email:NorthStarACT.referrals@turnbhs.org
☐ TURN BHS ACTION Central:	Phone (619) 287-8225; Fax (619) (619) 383-0386 Email:ACTIONCentralACT.referrals@turnbhs.org
☐ TURN BHS ACTION East:	Phone (619) 383-6868; Fax (619) 312-2661 Email:ACTIONEastACT.referrals@turnbhs.org

REFERRAL TO ASSERTIVE COMMUNITY TREATMENT – SUBSTANCE ABUSE TREATMENT PROGRAM (Dual Track Programs)

☐ TURN BHS ACTION Central:	Phone (619) 287-8225; Fax (619) (619) 383-0386 Email:ACTIONCentralSUD.referrals@turnbhs.org
☐ TURN BHS ACTION East:	Phone (619) 383-6868; Fax (619) 312-266 Email:ACTIONEastSUD.referrals@turnbhs.org

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: Language of Preference: Age: MIS#:

Aliases: Gender: Ethnicity:

Address: Phone:

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

Is he/she connected to Whole Person Wellness? ☐ YES ☐ NO

Alternate Telephone Number or Other Supports: 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 past year: 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:

CULTURAL FACTORS RELATED TO MENTAL HEALTH:

DIAGNOSES

Primary:

Secondary:

Other(s):

Medical condition(s) important to the understanding or management of an individual's mental disorder(s):

Psychosocial and contextual factors (use V&Z codes most relevant to the mental disorder):

CURRENT MEDICATONS:

Current Treating Psychiatrist: Phone:

CURRENT MEDICAL ISSUES:

Primary Care Physician: 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 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:

This electronic form can also be found in the Technical Resource Library (TRL).