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

SPECIALIZED BIOPSYCHOSOCIAL REHABILITATION CASE MANAGEMENT AND ASSERTIVE COMMUNITY TREATMENT

CLOSED REFERRAL SYSTEM

*** 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

- ☐ Telecare Pathways to Recovery (direct step-down referrals from County ICM*): (619) 683-3100; mailto:pathwaysreferrals@telecarecorp.com
- ☐ Telecare Gateway to Recovery (only High Utilizer referred from hospitals): (619) 683-3100; mailto:gatewayreferrals@telecarecorp.com
- ☐ Telecare Behavioral Health Collaborative Court (referrals from Justice Partners): (619) 276-1176; Fax (619) 276-1907
- ☐ Telecare Vida (referrals from Justice Partners except AB109 or parolee): (619) 332-5830; mailto:vidareferrals@telecarecorp.com
- ☐ Telecare Tesoro (referrals from Acute Care Hospitals for unconnected clients): (619) 320-2404; mailto:tesororeferrals@telecarecorp.com
- ☐ Telecare La Luz (referrals from Long Term Care for unconnected clients): (619) 320-2404; mailto:laluzreferrals@telecarecorp.com

REFERRAL TO INSTITUTIONAL CASE MANAGEMENT (ICM) PROGRAMS (direct referrals from Conservator's Office)

- ☐ County of San Diego ICM: (619) 692-8715; mailto:CCMreferrals@sdcounty.ca.gov
- ☐ Telecare AgeWise ICM: (619) 481-3850; mailto:agewise@telecarecorp.com

REFERRAL TO SHORT-TERM CASE MANAGEMENT PROGRAM

- ☐ Neighborhood House Association (NHA) Safe Connections (Behavioral Health Units at Grossmont, Bayview, and Paradise Valley): Phone (858) 285-0975; Fax (619) 881-8079; mailto:dbrittain@neighborhoodhouse.org

REFERRAL TO STRENGTH-BASED CASE MANAGEMENT (SBCM) PROGRAMS (direct referrals from Probation Department)

- ☐ Exodus AB 109 Program – Central Region: (619) 528-1752; Fax: (619) 528-1756
- ☐ Exodus AB 109 Program – North Coastal: (760) 305-4635; Fax: (760) 305-4636

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: Age: MIS#:

Aliases: Gender: Language of Preference: 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 MEDICATIONS:

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).