



KINGS COUNTY BEHAVIORAL HEALTH

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Behavioral Health Director

FULL-SERVICE PARTNERSHIP (FSP) WRAPAROUND REFERRAL FORM FOR CHILDREN/YOUTH

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REFERRAL INFORMATION

Date: _____ Preferred Language: _____

Child/youth First Name: _____ Child/youth Last Name: _____

DOB: _____ SSN: _____ Race/Ethnicity: _____

Gender: Female Male Transgender Gender nonconforming Other: _____

Address: _____ City: _____ ZIP Code: _____

Phone Number: _____ Current Living Arrangement: _____

Insurance: Medi-Cal Private None Other

Primary Contact: _____ Relationship: _____

Preferred Language: _____ Phone: _____

Conservator? No Yes, whom? _____

REFERRAL SOURCE

Referral Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Is child/youth currently receiving services from referral agency? Yes No

Other Agencies Involvement: CWS Probation Kings View CVRC Other _____

If child/youth was referred to any other programs, please identify: _____

FOCAL POPULATION

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Check appropriate reason(s) for referral of a Child with Serious Emotional Disturbance (SED) *

1. Zero to five –year-old (0-5) who:
 - is at risk of expulsion form pre-school
 - is involved with or high risk of being detained by Child Welfare System (CWS)
 - has a parent/ caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorder

2. Child/youth who:
 - has been removed or is at risk of removal from their home by CWS
 - is in transition to a less restrictive placement

3. Child/Youth is experiencing the following at school:
 - suspension or expulsion
 - violent behaviors
 - drug possession or use
 - suicidal and/or homicidal ideation

4. Child/youth who:
 - is involved with probation, and/or is on psychotropic medication, and/or has transitioned back into less structured home/community.

Provide detail for any checked item:

* *" Seriously emotionally disturbed" means minors under the age of 18 years 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 chap26.5(commencing with Section 7570) of Division 7 or Title 1 of the Government Code.[California Welfare and Institutions Code Section 5600.3]

LEVEL OF SERVICE

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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 mental health services, though insufficient to achieve desired outcomes**)*
- Inappropriately served (Receiving some mental health 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:

DIAGNOSTIC CONSIDERATION

Primary DSM V Diagnosis (if applicable): _____

Substance Use Disorder Diagnosis (if applicable): _____

Check all that applies to individual:

- | | |
|---|--|
| <input type="checkbox"/> Aggressive Ideation | <input type="checkbox"/> Inappropriate Sexual Ideation |
| <input type="checkbox"/> Aggressive Act (by history or current) | <input type="checkbox"/> Psychiatric Hospitalizations (indicate dates below) |
| <input type="checkbox"/> Aggressive Threats (by history or current) | <input type="checkbox"/> Suicidal Ideation/Attempts |
| <input type="checkbox"/> Fire Setting or Acts | <input type="checkbox"/> Symptoms of Psychosis |
| <input type="checkbox"/> Inappropriate Sexual Acts | <input type="checkbox"/> Tarasoff Notifications (past or current) |
| <input type="checkbox"/> Other: _____ | |

Provide Detail for Any Checked Items:

FAX complete form to Kings County Behavioral Health Attention: Children System of Care Program Manager at:
(559) 589-6928 or email to: kingsMHPcsoc@co.kings.ca.us

Child/Youth Name: _____

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DISPOSITION
To Be Completed by KCBH

Date received _____

Not pre-authorized for Enrollment (Explain reasons for decision and plan for linkage to other services):

Pre-authorized for Enrollment:

Name of FSP Agency: _____ Phone: _____ FAX: _____

Contact Person: _____ Phone: _____

KCBH Authorizing Representative: _____ Date: _____

To be completed by FSP Representative

Date Received: _____

FSP Agency has completed outreach and engagement (check only one box below):

Request authorization to enroll First contact date: _____ Scheduled assessment date: _____

Agency declines to enroll, but individual is eligible for FSP (must complete Appeal Form)

Individual does not agree to services (explain reason for decision and plan for linkages)

Individual is deemed ineligible for FSP Services (explain reasons and plan for linkages)

FSP Agency Representative: _____ Date: _____

To Be Completed by KCBH

Date Received: _____

NOT AUTHORIZED FOR ENROLLMENT (explain reason for decision): _____

AUTHORIZED FOR ENROLLMENT

KCBH Representative: _____ Date: _____

REFERRAL SOURCE NOTIFIED OF DISPOSITION ON _____ BY _____
Date FSP Representative