KINGS COUNTY
BEHAVIORAL HEALTH
Lisa D. Lewis, PhD
Behavioral Health Director

Kings County CARE ACT

1222 W. Lacey Blvd
Hanford, CA 93230
Phone: (559) 852-2444
FAX: (559) 589-6928
Email: CarecourtKCBH@co.kings.ca.us

Referral and Authorization Form

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Instructions Code, Civil Code, and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

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IDENTIFIED PARTICIPANT INFORMATION

EHR #_____

Date: _____ Preferred Language: _____

First Name:_____ Last Name: _____

DOB:_____ SSN:_____ Race/Ethnicity: _____

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Gender nonconforming ☐ Other

Last Known: _____ City: _____ ZIP Code: _____

Phone Number: _____ Current Living Arrangement: _____

Insurance: ☐ Medi-Cal ☐ Private ☐ None ☐ Other _____

Emergency Contact: _____ Relationship to client: _____

Emer. Cont. Preferred Language:_____ Emer. Cont. Phone: _____

Conservator? ☐ No ☐ Yes (Name):_____ Phone: _____

ROI: ☐ No ☐ Yes

Has the participant experienced recent incarceration (within last 6 months)?

☐ No ☐ Yes

If Yes, provide dates _____

_____

REFERRAL SOURCE

Referral Agency: _____ Petitioner Name: _____
Phone: _____ Fax: _____ Email: _____

Is the individual currently receiving services from the referral agency? ☐ Yes ☐ No

Other Agencies Involvement: ☐ APS ☐ Probation ☐ Behavioral Health ☐ Public Guardian ☐ Unknown ☐ Other

Name of other agency staff:_____

If an individual was referred to any other programs, please identify: _____

The individual is aware that a CARE Court referral has been made on his/her behalf: ☐ Yes ☐ No.

Last face-to-face contact date with the referring party: _____

Last known location:_____

EHR #: _____

Eligibility and Past History

Eligibility Criteria

Meets All of the Following:

☐18 years+

☐Experiencing a severe mental illness and has a diagnosis of schizophrenia spectrum or other psychotic disorders.

☐Severe and persistent symptoms, interfering with daily functioning

☐Not stabilized with ongoing voluntary outpatient treatment

☐Participation in the CARE Act is the least restrictive alternative.

☐Will benefit from participating in a CARE plan or CARE agreement At least one of the following

- ☐Unlikely to survive safely and deteriorating
- ☐Intervention needed to prevent relapses or deterioration

Past History:

Does the participant receive or has received treatment services?

☐No

☐Yes

If yes please describe below (i.e.ROS, FSP, Hospitalizations, Conservatorships:

_____

_____

_____

_____

For KCBH Use Only

Date Received: _____

Date Petition Was Filed: _____

Referral Source Notified of Filed Petition On _____ BY _____
Date **KCBH Representative**