KINGS COUNTY
behavioral health

FSP Referral Form

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Children/Youth Referral and Authorization form for
FULL SERVICE PARTNERSHIP WRAPAROUND

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 who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

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 Numbers:_____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:

Child/Youth Name: _____

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 mediation, 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]

Child/Youth Name: _____

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:

☐Aggressive Ideation
☐Aggressive Act (by history or current)
☐Aggressive Threats (by history or current)
☐Fire Setting or Acts
☐Inappropriate Sexual Acts
☐Other: _____

☐Inappropriate Sexual Ideation
☐Psychiatric Hospitalizations (indicate dates below)
☐Suicidal Ideation/Attempts
☐Symptoms of Psychosis
☐Tarasoff Notifications (past or current)

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 and (check only one box below):

First face to face contact Date: _____

☐ Request Authorization to enroll

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

☐ Individual does not agree to services (explain reasons 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