Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

To be used for Ventura County Priority Access to Services and Support (PASS) Program referrals only

TO BE FILLED OUT BY REFERRING CHILD WELFARE SOCIAL WORKER

Social Worker Name: _____ Phone: (____) _____ Email: _____

SW Supervisor Name: _____ Phone: (____) _____ Email: _____

Is the Referral Algorithm Complete? Yes/No No If no, why not?_____

Is the ROI included? Yes/No No If no ROI, why not?_____

Other documents included? Yes/No No If yes, what documents?_____

Detention Hearing Date:_____ Algorithm completion date:_____ Completed in 5 working days? Yes/No No

If not completed in 5 working days from date of Detention Hearing, why not?_____

Client contact used to complete the Referral Algorithm: Face to Face/Phone Call Face-to-Face

MEMBER/CLIENT INFO

Other (specify below)

Patient/Client Name: _____ _____Gender:M/F F Race/Ethnicity_____

(Last) (First)

Address: _____ City: _____ Zip: _____ Phone:(____) _____

Age in Years:_____ Date of Birth:(mo/day/year)_____ Client Language: _____

Client Medi-Cal# (CIN): _____ Private Insurance? Yes/No No If yes, provide name/ID_____

Primary Care Provider _____ Phone: (____) _____

Behavioral Health Diagnosis (if known): (1) _____ (2) _____ (3)_____

Desired behavioral health clinician/provider/program, if any:_____

Member already linked with New Start for Moms? Yes/No/Not Applicable Not Applicable

List A (check all that apply)	List B (Check all that apply)	List C
☐ Persistent symptoms & impairments after 2 recent medication trials ☐ Multiple co-morbid health and mental health conditions ☐ Behavior problems (aggressive/self-destructive/assaultive/extreme isolation) ☐ Excessive ED visits or 911 calls ☐ Bipolar disorder ☐ Trauma/recent loss/significant life stressors ☐ Depression /anxiety ☐ Homelessness/housing instability resulting from mental health condition	☐ 2 or more psychiatric hospitalizations within 12 months ☐ Functionally significant, non-substance induced paranoia, delusions, hallucinations, mania ☐ Current diagnosis of personality disorder with significant functional impairment ☐ Suicidal/Homicidal preoccupation or behavior in past year ☐ Transitional Age Youth with prodromal psychotic symptoms ☐ Eating disorder with medical complications	☐ Drug or alcohol addiction and failed SBI (screening & brief intervention at primary care). ***If client minimizes or denies substance abuse, continue with an ADP referral and provide additional information in the "Other Notes/ Comments" section below***

	Referral Algorithm	
1	Remains in PCP care with Beacon consult or therapy only (For Beacon therapy, use EFax to (855) 371-3947 or MC_GCHP@beaconhs.com and CQI-Help@ventura.org and Leanna.Ramirez@ventura.org)	☐ 1-2 in List A and none in List B
2	Refer to **Beacon Health Options** (eFax (855) 371-3947 or MC_GCHP@beaconhs.com and CQI-Help@ventura.org and Leanna.Ramirez@ventura.org)	☐ 3 in list A and none in list B OR ☐ Diagnosis excluded from county MHP
3	Refer to **Ventura County Behavioral Health** for assessment (email to Star.Pass@ventura.org and CQI-Help@ventura.org and Leanna.Ramirez@ventura.org)	☐ 4 or more in list A OR ☐ 1 or more in list B
4	Refer to **Ventura County Behavioral Health ADP** (email to VCBHADP_PASS@ventura.org and CQI-Help@ventura.org and Leanna.Ramirez@ventura.org)	☐ 1 from list C

Note: If the Algorithm could not be completed, forward this form ONLY to CQI-Help@ventura.org and Leanna.Ramirez@ventura.org

Date submitted to CQI-Help@ventura.org & Leanna Ramirez _____ Date sent to provider(s):_____

Based on the **completed** Referral Algorithm, referrals sent to (check all that apply):

1. Beacon Consult ☐ 2. Beacon Health Options ☐ 3. VCBH STAR ☐ 4. VCBH ADP ☐ **Always Send To: CQI** ☐ **Leanna Ramirez** ☐

Other notes/comments: _____

Member/Client Pertinent Current/Past Information:

Current symptoms and impairments:

_____

Brief psychiatric, substance abuse, and medical history (as available):

_____

Current Medication(s) & Dosage

_____

TO BE FILLED OUT AT THE COMPLETION OF THE REFERRAL BY RECEIVING AGENCY. CHECK ALL THAT APPLY.
Send to CQI-Help@ventura.org and the referring Child Welfare Social Worker

Beacon Consult

Referral Received Date_____ Appt. Date:_____ Completed in 5 working days? Yes/No No
If not completed in 5 working days from date of Referral, why not?_____
Assessment Date_____ Service Date_____ Client declined services: Y/N No
If client declined, reason why:_____
Unable to reach client: Y/N No
Eligible for Services: Y/N No If not eligible, why not?_____
Linked with a provider: Y/N No If not linked, why not?_____
Other Notes/Comments:_____

Beacon Health Options

Referral Received Date_____ Appt. Date:_____ Completed in 5 working days? Yes/No No
If not completed in 5 working days from date of Referral, why not?_____ _____
Assessment Date_____ Service Date_____ Client declined services: Y/N No
If client declined, reason why:_____
Unable to reach client: Y/N No
Eligible for Services: Y/N No If not eligible, why not?_____
Linked with a provider: Y/N No If not linked, why not?_____
Other Notes/Comments:_____

VCBH STAR

Referral Received Date_____ Appt. Date:_____ Completed in 5 working days? Yes/No No
If not completed in 5 working days from date of Referral, why not?_____ _____
Assessment Date_____ Service Date_____ Client declined services: Y/N No
If client declined, reason why:_____
Unable to reach client: Y/N No
Eligible for Services: Y/N No If not eligible, why not?_____
Linked with a provider: Y/N No If not linked, why not?_____
Other Notes/Comments:_____

VCBH ADP

Referral Received Date_____ Appt. Date:_____ Completed in 5 working days? Yes/No No
If not completed in 5 working days from date of Referral, why not?_____ _____
Assessment Date_____ Service Date_____ Client declined services: Y/N No
If client declined, reason why:_____
Unable to reach client: Y/N No
Eligible for Services: Y/N No If not eligible, why not?_____
Linked with a provider: Y/N No If not linked, why not?_____
Other Notes/Comments:_____