BEACON

Bi-Directional Medi-Cal Mental Health Level of Care Transition Form

INSTRUCTIONS: Complete this form when transitioning a Medi-Cal client in active services between levels of mental health care. Please provide details on the type of transition requested and also provide the clinical information on page 2. Clinical information can be completed on the form **OR** with last two progress notes and medication log (if applicable). When transitioning to the Managed Care Plan (mild to moderate impairment) level of care, please fax the completed form to Beacon at **877-768-2306**.

Member Demographics

Client Name: _____ Date of Birth: ____/_____/_____ ☐ M ☐ F ☐ O
(Last) (First)

Client phone _____ Medi-Cal Health Plan _____

Medi-Cal ID# _____ Language/Cultural Requirements _____

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

Caregiver/Guardian: _____ Phone: (_____) _____
(Name) (Relationship)

Transition Request Details

Reason for transition

☐ **TO BEACON**: No longer meets medical necessity for Specialty MH Services (SMHS) (mild to moderate impairments due to MH Dx)

☐ **TO COUNTY**: Meets medical necessity for Specialty MH Services assessment and requires more intensive services

☐ Other _____

Member notified of transition for services: ☐ Yes ☐ No

Medication Management requested/ to be managed by:

☐ Primary Care ☐ Beacon contracted psychiatrist ☐ County SMHS ☐ Other_____ ☐ N/A

Therapy requested/to be managed by:

☐ Beacon contracted therapist ☐ County SMHS ☐ Other_____ ☐ N/A

If member formerly saw Beacon provider, name/clinic of that provider: _____ or ☐ N/A

Attached Documents *(check any that apply)*: ☐ Screening tool ☐ Progress notes ☐ Medication Log ☐ Discharge summary ☐ Other _____

Consent to share PHI: ☐ Release of Information (ROI) attached ☐ Verbal consent (date received) _____

Sending Clinician Info

Staff name: _____ Title/licensure: _____

Date: _____ Phone: (_____) _____ Email: _____

BEACON

Clinical Information

Primary Diagnosis: _____ **Secondary Diagnosis**: _____

Admit Date: _____ **Discharge Date:** _____

Medication	Dose	Last Change Date

Services provided to member while in SMHS or Beacon level services:

☐ Medication Management ☐ Psychological Testing ☐ Individual/Group Therapy

☐ TBS ☐ Case Management ☐ Wrap services

☐ Crisis Intervention ☐ Other _____

Risk Factors:

☐ Psychiatric hospitalization within last year. If yes, date_____.

☐ Active S/I or H/I with plan or intent. If yes, please describe below.

☐ Recent trauma/loss. If yes, please describe below.

☐ Recent release from prison system. If yes, please describe below.

☐ Increased psychosocial issues exacerbating MH condition. If yes, please describe below.

Relevant Clinical information: