ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES
SUBSTITUTE PAYEE PROGRAM REFERRAL FORM

Instructions: Every blank must be filled in and all questions answered. If information is unavailable, write "UNK" or "NA." However, referral may be delayed in processing. For more space, attach additional sheet. **Clients are not to complete this form**.

♦Do Not Fax ♦ All Forms Must Be Mailed In ♦ Only Originals Will Be Accepted♦

►Client Name: ______________________ (PRINT) ►D.O.B.____________ ►BHCS #____________ (Insyst Client I.D)

►AKA/Maiden Name____________________ ►SSN____________ ►Last Grade Completed: _____

►Sex ________ ►Marital Status: ______________ ►Ethnicity:______________________

►City & State or Country of Birth:______________________ ►Is client a U. S. citizen? ☐Yes ☐No

►Mother's Maiden Name:______________________ PROVIDE FIRST AND LAST NAMES ►Father's Name:______________________ PROVIDE FIRST AND LAST NAMES

►Amount Of SSI $____________ ►Amount Of Social Security: $____________ ►Is SSI and/or SSA Pending? ☐Yes ☐No If YES, provide the date of application: ______________

►Is client employed? ☐Yes ☐No ►If Yes: Attach Current Wage Stub ►Date started working: ____________

►Does client have other income? ☐Yes ☐No ►If YES Type Or Source: ______________ ►Amount: $__________ PER MONTH

►Does client have a checking and/or savings account? ☐Yes ☐No ►If YES, attach copy of current statement for each account.
►Does client have a Burial Trust or Life Insurance? ☐Yes ☐No ►If YES, attach a copy of the policy or contract.

Please Note: Payee application cannot be processed without a copy of the bank statement, policy and/or wage stubs.

►Current Diagnosis:______________________ ►GAF:______ ►Prior year GAF:______

►Provide Code Numbers For: ►Axis I __________ ►Axis II__________ ►Axis IV__________ ►Axis V__________

►Has client been hospitalized in the last year in a mental health facility? ☐Yes ☐No ►If YES, check which facility/facilities:

☐John George Pavilion ☐Herrick Hosp. ☐Fremont Hosp. ☐Villa Fairmont ☐Gladman ☐Garfield ☐Morton Bakar ☐Napa ☐Atascadero ☐Patten ☐Other (Give Name)______________________

♦♦

►Address Where Client Is Currently Residing:
►(If Homeless or Transient, Write "Homeless" or "Transient")

____
▲Name Of: Facility/Board & Care Home/Hospital/Jail/Hotel/Motel/Shelter▲

____
▲Street Address▲

____
▲City & State▲ ▲ ZIPCode ▲

▼Effective Date at Current Address▼

MO.►______DAY►______YR►______

Referral will not be processed if the full date is not provided.

►Type of Living Arrangement – Check The Box Or Boxes That Apply:

☐Licensed Board & Care Home ☐Private Home ☐Apt. ☐Hotel or Motel ☐IMD Or Hospital

☐Lives With Friends Or Relatives ☐Room & Board Home (Unlicensed) ☐On The Streets ☐Transient

►ANSWER ALL QUESTIONS BELOW:

►Rent Amount $ ______________
►Does client have access to a working stove or microwave? ☐Yes ☐No ►Does client have access to a working refrigerator? ☐ Yes ☐No ►Is at least one meal provided per day? ☐Yes ☐No ►Is client in a shelter? ☐Yes ☐No
►If client does not live in a Licensed Home or Room and Board Home, does he/she live with others? ☐Yes ☐No
►If Yes: Does client share household expenses? ☐Yes ☐No ►How many people live in the household? ________

♦♦

►Is client conserved? ☐Yes ☐No ►If yes, provide name & address of conservator:______________________

____

►Is the client his/her own payee? ☐Yes ☐No ►IF Yes: Signed Dr. Statement is required

►Current Payee's Name & Address: ______________________

______________________ ►Phone #______________ ►Relationship:______________

►Does current payee approve of transfer to Sub-Payee Program? ☐Yes ☐No (IF Yes: Relinquishment letter may be needed)

(Continued on Reverse Side)

►THERAPIST COMMENTS: Briefly explain why this client needs Alameda County Substitute Payee Program to be their payee and/or why the current payee is inappropriate. Include the reason why no family member can take on this responsibility. (You may attach recent social/psychological histories to supplement).

_____

_____

_____

_____

_____

►List any serious physical disabilities:_____

►Provide name(s) and address(es) of family member(s) or other contact persons: _____

_____

►Relationship:_____ ►Phone Number:_____

►Please rate the objectives below according to the degree to which you feel being on Sub-Payee can help your client achieve them over the next 12-month period. Place a rating number in the blank next to each area of improvement using the following rating scale: (if category is not applicable, write "N/A")

(1)	(2)	(3)	(4)	(5)
No improvement expected in this area	Little improvement expected	Moderate improvement	Significant improvement	Maximum improvement

_____Client will remain in the same placement/living arrangement for at least _____ months.

_____Client will take part in regular treatment (e.g. take prescribed meds, come to appointments, etc.).

_____Sub-Payee Program will improve family relations (e.g. facilitate client independence, help diffuse family conflicts, etc.).

_____Client will learn to manage his or her money better.

_____Sub-Payee Program will prevent client from being taken advantage of (e.g. through theft, inappropriate loans, lost checks, etc.).

_____Sub-Payee Program will prevent client's use of funds for self-abusive or otherwise inappropriate purposes (e.g. drug/alcohol, etc.).

_____Other expected improvements:_____

►Assigned Case Manager: _____ ►Staff #:_____
(PRINT NAME)

►Program Or Site:_____ ►Phone #:_____

►If You Are Not The Case Manager For This Client:
►Is Current Case Manager Aware Of And Agrees To This Referral? □Yes □No

►Submitted By: _____ ►Program or Site:_____ ►Phone #:_____
(Print Your Name and Sign Below)

►Signature:_____ ►Date:_____

►Send Original Referral To:

DO NOT FAX

Sub-Payee Clinical Liaison
Oakland Community Support Center
7200 Bancroft Avenue, Suite 125A
Oakland, CA 94605

If you have any questions contact Clinical Liaison at (510)777-3863 (33863) or Sub-Payee Supervisor at (510) 383-1567 (31567)

►For Alameda County BHCS Case Managers: Send original referral via QIC 24560.

FOR CLINICAL LIAISON ONLY: Date received:_____ □Approved □Denied Date:_____Initials:_____

FOR SUB-PAYEE UNIT SUPERVISOR ONLY: Date received:_____ □Approved □Denied Date:_____Initials:_____

FOR SUB-PAYEE OFFICE USE ONLY: ASSIGNED TO:_____ON_____