**GUIDELINES/PROMPTS:**

1. A Full MH Assessment may not be required for every new episode of care. Use the one-page MH Assessment Update if: importing a full MH Assessment that was done in the past 12 months in your program, or importing a full MH Assessment from a program conducted in the past 6 months.

2. If a full MH Assessment may not be completed by day 60 for clinical reasons, indicate reason and you may continue to claim for unplanned services (crisis, assessment, plan development, case mgt for linkage, meds for urgent need).

3. If a one-page Interim MH Assessment is completed by day 30 of EOD, a full MH Assessment is not due until day 60.

4. If any information is unable to be collected in the MH Assessment, or inappropriate to collect at this time (due to client’s individual circumstances) indicate this and when attempts will be made again.

5. Pay special attention to wording such as “when clinically relevant”. Examples may be provided, but it is not necessary to inquire into each one—this is determined by the assessor’s clinical judgement.

6. Any statements beginning with “PROMPT” are instructions and will not be present in the finalized MH Assessment copy.

Allergies

|  |
| --- |
| Yes  No |
| No new allergies reported |

**Episode Opening Date**:  **Birthdate**:  **Age:**  **Preferred** **Language**: Choose an item.

**Preferred** **Last Name:**  **Preferred First Name**: 

**What is your Pronoun**: She/Her: **** He/Him: **** They/Them: **** Unknown/ Not Reported: ****Other: ****

**Sex Assigned at Birth**: Male: **** Female: **** Other: ****

**Gender Identity:** Unknown: **** Male: ****Female: ****Intersex: ****Gender Queer: **** Gender non-conforming: ****

Prefer Not to Answer: ****Other: ****

Transgender: Male to Female/Transgender Female/Trans Woman Female to Male/Transgender Male/Trans Man

**SEXUAL** **ORIENTATION**: Unknown: **** Bisexual: **** Declined to State: ****Gay: ****Gender Queer: ****

Heterosexual/Straight: ****Lesbian: ****Questioning: ****Queer: ****Other: ****

**Emergency Contact:**  Relationship: 

**Contact Address (Street, City, State, Zip): ** **Contact Phone #: **

****Release for Emergency Contact obtained for this time period (or contact is legal representative and release not needed): 

|  |
| --- |
| **ASSESSMENT MENTAL HEALTH** |

**Initial Update**

**Informing Materials signed (annually)** **Release of Information Forms signed (annually)**

|  |
| --- |
| **INITIAL ASSESSMENT SUMMARY** |

**Assessment Sources of Information (Check All that Apply):**

Client: **** Family Guardian: **** Hospital: **** Other: ****

**REFERRAL SOURCE/REASON FOR REFERRAL/CLIENT COMPLAINT:**

Describe precipitating event(s) for Referral:



Current Symptoms and Behaviors (intensity, duration, onset, frequency; present/new precipitants/stressors; for episodic illnesses describe first episode, onset, precipitants, duration & Rx response; etc.):



Impairments in Life Functioning caused by the MH symptoms/Behaviors (from perspective of client and/or others):



|  |
| --- |
| **MENTAL HEALTH HISTORY** |

**Psychiatric Hospitalizations / Outpatient Treatment:** Yes: **** No: **** Unable to Assess: ****

If Yes, describe any known dates, locations, reasons, response to, and satisfaction with treatment:



**Prior Mental Health Records Requested:** Yes: **** No: ****

(See InSyst Face Sheet for current and history of past services)

**Prior Mental Health Records Requested from:**

 

**History of Trauma or Exposure to Trauma:** Yes: ****No: **** Unable to Assess: ****

**PROMPT:** Describe clinically relevant traumas that may be like: (1) been physically hurt or threatened by another, (2) been raped or had sex against their will, (3) lived through a disaster, (4) been a combat veteran or experienced an act of terrorism, (5) been in severe accident, or been close to death from any cause, (6) witnessed death or violence or the threat of violence to someone else, or (7) been the victim of crime (8) Prolonged separation from parent/caregiver/family? Describe:



**Risk factors:** Yes ****No: **** Unable to Assess: ****

**Indicate all clinically relevant risk factors.**

**PROMPT**: DHCS has elaborated the following circumstances as placing the client at higher risk: Current or History of Danger to Self (DTS) or Danger to Others (DTO); Previous inpatient hospitalizations for DTS or DTO; Prior suicide attempts; Lack of family or other support systems; Arrest history; Probation status; History of alcohol/drug abuse; History of trauma or victimization; History of self-harm behaviors (e.g., cutting); History of assaultive behavior; Physical impairments (e.g. limited vision, deaf, wheelchair bound) which makes the beneficiary vulnerable to others; Psychological or intellectual vulnerabilities [e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality]. Describe any relevant factors that increase risk (frustration tolerance, hostility, paranoia, command hallucination, exploitative behaviors and any relevant factors that might lessen such risk such as client’s commitment to self-control and involvement in treatment.



**Please check if occurred within the last 30 days**: **** Date of onset: 

Safety plan will be completed with Client Plan if any S/I, H/I, or other High Risk in past 90 days. Reports Filed as a result of this Assessment: N/A CPS APS Other

|  |
| --- |
| **PSYCHOSOCIAL HISTORY** |

**Family History**

Include any clinically relevant factors such as: current family make-up--required; family of origin; family history of: mental illness and suicide--required, substance abuse, domestic or child abuse/neglect (physical, sexual, emotional, etc.); arrests/court proceedings; immigration status, etc.



**Cultural Formulation:**

**PROMPT**: Consider any clinically relevant cultural factors which may influence presenting problems as viewed by client/family/caregiver and the clinician. Factors may include ethnicity, race, religion, spiritual practice, sexual orientation, gender identity, caregiver or client socio economic status, living environment. Consider how special treatment issues result from the client’s/family diversity AND how it may be a strength for the client.



**This Section for YOUTH ONLY < 18 YRS OLD**

|  |
| --- |
| **This Section for YOUTH ONLY < 18 YRS OLD** |

**LIVES WITH:** Immediate Family: ****Extended Family: **** Foster Family: ****Other: ****

First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

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First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

First Name of others in home (children & adults):  Age:  Relationship: 

**EDUCATION**: Optional Notes:  Special Ed: Yes: ****No: ****Grade: 

Optional Contact/Teacher Ph#: 

Active IEP/Special Assessment/Services (Describe):  LD: ****DD/ID: ****SED: ****

**Last School Attended: **

**Vocational Activities (Optional): **

**Would client like assistance with accessing any vocational activities such as education, vocational training, job supports, etc.?** Yes: **** No: ****

**Developmental History (for each section also include any significant culturally related rites of passage, rituals, ceremonies, etc.)**

Prenatal/birth/childhood 0 – 6 yrs.

**PROMPT**: As clinically relevant describe events such as: pregnancy, developmental milestones, environmental stressors, and other significant events.



**Latency 7 – 11 yrs.:** N/A: ****

**PROMPT**: As clinically relevant describe events such as: peer/sibling relations, extracurricular activities, delinquency, environmental stressors of other significant events).



**Adolescence 12-17 yrs. N/A: **

**PROMPT**: As clinically relevant describe events such as: onset of puberty, extracurricular activities, teen parenthood, delinquency, gang involvement, environmental stressors of other significant events.



|  |
| --- |
| **LEGAL HISTORY** |

Legal History:

**PROMPT**: Describe any clinically relevant legal encounters for client or family such as: landlord/tenancy; employment; family;

criminal; immigration, etc.



|  |
| --- |
| **MEDICAL HISTORY** |
|  | **Name** | **Address** | **Phone #** | **Last Date of Service** |
| **Primary Physician** |  |  |  |  |
| **Other medical provider(s):**  |  |  |  |  |
| **Date records requested: From whom, if applicable:** |  |  |  |  |

**Relevant Medical History:** Indicate or check only those that are relevant

**General Information**: Reported Weight (lbs.):  Reported Height (in): 

Height/Weight WNL: 

Weight Changes: **** Describe: 

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cardiovascular/Respiratory: | Chest Pain  | Hypertension  | Hypotension  Palpitation  | Smoking  |
| Genital/Urinary/Bladder: | IncontinenceUrgency | Nocturia | Urinary Tract Infection | Retention |
| Gastrointestinal/Bowel: | HeartburnUlcers | DiarrheaLaxative Use | Constipation NauseaIncontinence | Vomiting |
| Nervous System: | Headaches | Dizziness | Seizures  Memory | Concentration |
| Musculoskeletal: | Back Pain | Stiffness Arthritis | Mobility/Ambulation |
| Gynecology: | Pregnant | Pelvic Inflam. Disease | Menopause Breast Feeding |
| Skin: | Scar | Lesion | Lice | Dermatitis | Cancer |
| Endocrine: | Diabetes | Thyroid | Other: |  |  |
| Respiratory: | Bronchitis | Asthma | COPD | Other: |  |

Optional Comments



**Others (check if relevant and describe):**

****Other: Significant Accident/Injuries/Surgeries: 

****Hospitalizations: 

****Physical Disabilities: 

****Chronic Illness: 

****HIV disease: 

****Age of Menarche and Birth Control Method: 

****History of Head Injury: 

****Liver Disease: 

****None of the Above

**Alternative healing practice/date (e.g., acupuncture, hypnosis, herbs, supplements, etc.)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Provider / Type** | **Reason for Treatment** | **Outcome (was it helpful and why)** |
|  |  |  |  |
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|  |  |  |  |
| **MEDICATIONS** |
| **CURRENT MEDICATIONS**(include all prescribed, over the counter, and holistic/complimentary/alternative remedies): |
|  | **Medication Name** | **Effectiveness/Side****Effects if known** | **Dosage****if known** | **Date Started****if known** | **Prescriber if known** |
| Psychotropic |  |  |  |  |  |
|  |  |  |  |  |
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| Non- Psychotropic |  |  |  |  |  |
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| **PREVIOUS MEDICATIONS** (include all prescribed, over the counter, and holistic/complimentary/alternative remedies): |
|  | **Medication Name** | **Effectiveness/Side****Effects if known** | **Dosage****if known** | **Date Started****if known** | **Prescriber if known** |
| Psychotropic |  |  |  |  |  |
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|  |  |  |  |  |
| Non- Psychotropic |  |  |  |  |  |
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Date of last physical exam (if known):  Date of last dental exam (if known):

Referral made to primary care or specialty: No: **** Yes: **** If yes, list: 

Providers, including Address, Phone, E-mail (if known):



Additional Medical Information: If needed, describe any relevant medical conditions.



|  |
| --- |
| **Therapeutic Foster Care (TFC), Intensive Care Coordination (ICC),****And Intensive Home Based Services (IHBS)** |

All Beneficiaries must be assessed to determine if they qualify and need Therapeutic Foster Care (TFC), Intensive Care Coordination (ICC), and Intensive Home-Based Services (IHBS).

Please check this box to indicate that client has been assessed for these services.

[ ]  TFC/ICC/IHBS

Check if a referral was made:

[ ]  TFC [ ]  ICC [ ]  IHBS

Narrative (Optional):



|  |
| --- |
| **SUBSTANCE USE SCREENING** |

****Child is under 11 years and SUD screening indicates exposure if known (otherwise regardless of age indicates client use).

|  |
| --- |
| **SUBSTANCE USE/EXPOSURE & DISORDERS** |
| **Category****(indicate if ever used)** | **Exposure** | **Past** | **CURRENT SUBSTANCE USE & PROBLEMS**  |
| **Prenatal** | **Current** | **Age at****first use****(if****known)** | **Current Use** | **Client-Perceived Problem** |
| **Yes** | **No** |
| **ALCOHOL** |  |  |  |  |  |  |
| **AMPHETAMINES****(SPEED/UPPERS, CRANK, ETC)** |  |  |  |  |  |  |
| **COCAINE/CRANK** |  |  |  |  |  |  |
| **OPIATES****(HEROIN, OPIUM, METHADONE)** |  |  |  |  |  |  |
| **HALLUCINOGENS (LSD,****MUSHROOMS, PEYOTE, ECSTASY)** |  |  |  |  |  |  |
| **SLEEPING PILLS, PAIN KILLERS,****VALIUM, OR SIMILAR** |  |  |  |  |  |  |
| **PCP (PHENCYCLIDINE) OR****DESIGNER DRUGS (GHB)** |  |  |  |  |  |  |
| **INHALANTS****(PAINT, GAS, GLUE, AEROSOLS)** |  |  |  |  |  |  |
| **MARIJUANA/ HASHISH** |  |  |  |  |  |  |
| **TOBACCO/NICOTINE CAFFEINE (ENGERY DRINKS,****SODAS, COFFEE, ETC.)** |  |  |  |  |  |  |
| **OVER THE COUNTER** |  |  |  |  |  |  |
| **RX MEDS - NOT PRESCRIBED OR TAKEN PER RX** |  |  |  |  |  |  |
| **COMPLIMENTARY/ALTERNATIVE MEDICATION** |  |  |  |  |  |  |
| **OTHER SUBSTANCE** |  |  |  |  |  |  |
| **Is beneficiary receiving alcohol and** | Yes, from this provider | Yes, from a different provider | No |
| **Is beneficiary receiving alcohol and****drug services?** | Residential | Outpatient | Community/ Support Group |
|  **SUBSTANCE RISKS, USE, & ATTITUDES/EXPOSURE (Required if “Higher Risk”)** |
|  | **NO** | **YES** | **UNABLE TO ASSESS** |
| **Were any risk factors identified based on clinical judgment?** |  |  |  |
| **Does the client currently appear to be under the influence of alcohol or drugs?** |  |  |  |
| **Has the client ever received professional help for his/her use of alcohol or drugs?** |  |  |  |

**Comments on alcohol/drug use (indicate if unable to assess at this time but plan on doing so in the future as treatment proceeds):**



**How is the mental health impacted by substance use (clinician’s perspective)? Must be completed if any services will be directed towards substance Use/Abuse, such as Case Management.**



|  |
| --- |
| **SUBSTANCE ABUSE/SEVERITY ASSESSMENT** |

**A. Beneficiary self-assessment:**

****Unable to assess at this time but plan on doing so in the future as treatment proceeds.

**** No alcohol or drug use

****Alcohol or drug use with no related problems

****Alcohol or drug use with related problems

**B. Provider assessment:**

****Unable to assess at this time but plan on doing so in the future as treatment proceeds.

****Use (minimal or no alcohol or drug relation problems)

****Substance abuse (frequent and/or periodic use associated with alcohol or drug problems)

****Substance dependence in recovery (prior significant, but now minimal or no substance related problems)

****Substance dependence not in recovery (uncontrolled use with significant alcohol or drug related problems)

|  |
| --- |
| **SUD REFERRALS** |

**Check below, for any referral made based on abuse assessment. List specific referral below.**

****Referral to SUDS (Substance Use Disorder Services) ACCESS line #1-800-491-9099 for:

Self-help groups- groups for consumer’s interested in support of sobriety include AA, NA, and Dual Recovery

****Anonymous. Referral should ideally be to a group known to support clients in psychiatric recovery

****Alcoholic Anonymous 510-839-8900

****Moderation Management:paulstayley@comcast.net or www.moderation.org

****Narcotics Anonymous (www.na.org)

****Nicotine Anonymous (www.nicotine-anonymous.org)

****Nicotine Quit Line (www.nobutts.org and 1-800-NO-BUTTS)

****SMART Recovery (www.SMARTrecovery.org)

****Outpatient counseling- for consumer’s assessed at abuse level, and who have an environment supportive of recovery.

****Residential treatment- for chemically dependent consumer’s with a low level of function, requiring an intense level of

support to initiate sobriety.

****Detoxification- for chemically dependent consumers who are at risk of at least moderate withdrawal symptoms, and

who require high level of structure to initiate sobriety.

****Other (specify): 

From the ACBHCS SUD Treatment Referral Guide, [www.acbhcs.org/providers/SUD/resources.htm](file:///%5C%5Cbhcsfile1%5Cusers%5CWhitfieldLa%5CMH%20Assessment%20CG%20Templates%5Cwww.acbhcs.org%5Cproviders%5CSUD%5Cresources.htm), indicate the specific referrals provided to client. Make a copy for the client to take with them to follow-up with referral.

|  |  |  |
| --- | --- | --- |
| **AGENCY** | **ADDRESS** | **TELEPHONE NUMBER** |
|  |  |  |
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|  |  |  |
| **MEDICAL NECESSITY – MENTAL STATUS** |
| **MENTAL STATUS** (Check and describe if abnormal or impaired) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Appearance/Grooming:** | Unremarkable | Remarkable for: |  |
| **Behavior/Relatedness:** | Unremarkable | Motor Agitated | Inattentive | Avoidant |
| Impulsive | Motor Retarded | Hostile | Suspicious/Guarded |
| Other:  |  |
| **Speech:** | Unremarkable | Remarkable for: |  |
| **Mood/Affect:** | Unremarkable | Anxious | Depressed | Elated/Expansive |
| Labile | Irritable/Angry | Other |  |
| **Thought Processes:** | Unremarkable | Concrete | Distorted | Disorganized |
| Odd/Idiosyncratic | Blocking | Circumstantial |  |
| Tangential | Obsessive | Flight of ideas |  |
| Loosening of Assoc | Other: |  |
| **Thought Content:** | Unremarkable | Hallucinations | Delusions |  |
| Other |  |
| **Perceptual Content:** | Unremarkable | Hallucinations | Homicidal Ideation | Paranoid Reference |
| Flashbacks | Depersonalization | Derealization | Dissociation |
| Suicidal Ideation | Other: |  |
| **Fund of Knowledge:** | Unremarkable | Remarkable for: |  |
| **Orientation:** | Unremarkable | Remarkable for: |  |
| **Memory:** | Unremarkable | Impaired |  |
| **Intellect:** | Unremarkable | Remarkable for: |  |
| **Insight/Judgment:** | Unremarkable | Remarkable for: |  |

***REQUIRED:* Describe all Mental Status Exam abnormal/impaired findings from above:**



|  |
| --- |
| **FUNCTIONAL IMPAIRMENTS** |
|  | **None** | **Mild** | **Mod** | **Severe** |  | **None** | **Mild** | **Mod** | **Severe** |
| **Family Relations** |  |  |  |  | **Substance Use/Abuse** |  |  |  |  |
| **School Performance/Employment** |  |  |  |  | **Activities of Daily Living** |  |  |  |  |
| **Self-Care** |  |  |  |  | **Episodes of decompensation & increase of symptoms, each of extended duration** |  |  |  |  |
| **Food/Shelter** |  |  |  |  | **Other (Describe):** |  |
| **Social/Peer Relations** |  |  |  |  |  |  |  |  |  |
| **Physical Health** |  |  |  |  |  |  |  |  |  |

***REQUIRED, describe Impairments checked above:***

****

|  |
| --- |
| **TARGETED SYMPTOMS** |
|  | **None** | **Mild** | **Mod** | **Severe** |  | **None** | **Mild** | **Mod** | **Severe** |
| Cognition/Memory/Thought |  |  |  |  | **Perceptual Disturbance** |  |  |  |  |
| School Attention/Impulsivity |  |  |  |  | **Oppositional/Conduct** |  |  |  |  |
| Socialization/Communication |  |  |  |  | **Destructive/Assaultive** |  |  |  |  |
| Depressive Symptoms |  |  |  |  | **Agitation/Lability** |  |
| Anxiety/Phobia/Panic Attack |  |  |  |  | **Somatic Disturbance** |  |  |  |  |
| Affect Regulation |  |  |  |  | **Other (Describe):** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

**Comments (if any):**

****

|  |
| --- |
| **BARRIERS / IMPAIRMENTS** |
| **Impairment Criteria (must have one of the following):****Select A, B, and C as they apply** | **AND** | **Intervention Criteria (proposed INTERVENTION****will….):** |
| A. Significant impairment in an important area of life function. | **AND** | Significantly diminish impairment |
|  B. Probability of significant deterioration in an important area of functioning. | **AND** | Prevent significant deterioration in an important areaof life functioning. |
|  C. (Under 21) Without treatment will not progress developmentally as individually appropriate. | **AND** | (Under 21) Probably allow the child to progressdevelopmentally as individually appropriate. |
|  D. None of the above | **AND** | None of the above |

**Diagnostic Summary (Optional):** (Be sure to include assessment for risk of suicidal/homicidal behaviors, significant

strengths/weaknesses, observations/descriptions, symptoms/impairments in life functioning, i.e. Work, School, Home,

Community, Living Arrangements, etc. and justification for diagnosis)

****

|  |
| --- |
| **Diagnostic Impression** |
| **DSM-5: Mental Health-** **see Medi-Cal included list** |
| **DSM-5 Descriptor** | **ICD-10** | **ICD-10 Descriptor** |  |
|  |  |  | **PRIMARY** |

Signs & Symptoms that Support Diagnosis or Per History:

****

Add Additional Diagnosis

****

**IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.**

**Coordinate Diagnoses with other clinicians**

|  |
| --- |
| **Diagnostic Impression** |
| **DSM-5: Substance Use-** see Medi-Cal included list |
| **DSM-5 Descriptor** | **ICD-10** | **ICD-10 Descriptor** |  |
|  |  |  | Rule out |

Signs & Symptoms that Support Diagnosis or Per History:

****

Add Additional Diagnosis

****

**IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.**

**Coordinate Diagnoses with other clinicians**

|  |
| --- |
| **Physical Health: General Medical Codes- see general medical code list** |
| **General Medical Codes** |
|  **(code)** | **(diagnosis)** | Rule out |

Signs & Symptoms that Support Diagnosis or Per History:

****

Add Additional Diagnosis

****

**IF DX HAS CHANGED, YOU MUST CORRECT INSYST FOR CORRECT CLAIMING.**

**Coordinate Diagnoses with other clinicians**

|  |
| --- |
| **DSM-5: Psycho Social** |
| **DSM-5 Descriptor** | **ICD-10** | **ICD-10 Descriptor** |  |
|  |  |  | Rule out |

Signs & Symptoms that Support Diagnosis or Per History:

****

Add Additional Diagnosis

****

Optional Disability Measures (WHODAS, etc.)

****

Disposition / Recommendations/ Plan (Optional)

****

**Diagnosis Established by:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Staff** | **Responsible Staff** | **License (professional suffix)** |
|  |  |  |  |

If established by waivered clinician, also provide licensed supervisor's name and licensure.

Licensed LPHA Co-Signer of Waivered Staff Above License **** (professional suffix) ****

Staff member waivered Type: ****

|  |  |
| --- | --- |
| **Mild-Moderate vs Moderate-Severe Level Determination** |  |
| **List A** (Check all that apply) | **List B** (Check all that apply) | **List C** |
| Impulsivity/Hyperactivity | 1 or more psychiatric hospitalization(s) in pastyear | Substanceabuse |
| Trauma/recent loss | Suicidal/homicidal preoccupations or behaviors in past year |  |
| Withdrawn/Isolative | Self-injurious behaviors |  |
| Mild-moderate depression/anxiety | Paranoia, delusions, hallucinations |  |
| Behavior problems (aggressive/selfdestructive/assaultive/bullying/oppositional) | Currently in out-of-home foster care placement |  |
| Significant family stressors \* | Juvenile probation supervision with currentplacement order |  |
| CPS report in the last 6 months | Functionally significant depression/anxiety |  |
| Excessive truancy or failing school | Eating disorder with medical complications |  |
| Difficulty developing and sustaining peer relationships | At risk of losing home, child care, or preschoolplacement due to mental health issue |  |
| Eating disorder without medical complications |  |  |
| Court dependent or ward of court |  |  |
| May not progress developmentally as individuallyappropriate without mental health intervention |  |  |

**\* Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing or homelessness.

|  |
| --- |
| **Referral Algorithm** |
| 1 | Remains in **PCP care** with Beacon consult or therapy only | 1 in List A and none in List B |
| 2 | Refer to **Appropriate Managed Care Plans (MCP):**Alameda Alliance/Beacon Phone: 1-855-856-0577Fax: 866-422-3413Kaiser Permanente Phone: 510-752-1075Anthem Blue Cross Phone: 1-888-831-2246 | 2 in list A and none in List B OR |
| Diagnosis excluded from county MHP |
| 3 | Refer to **County Mental Health Plan** for assessment(Phone: 1-800-491-9099 Fax: 510-346-1083) | 3 or more in List A OR |
| 1 or more in List B1 in List C |

**Referring Provider Name:  Phone: **

Referring/Treating Provider Type: PCP MFT/LCSW ARNP Psychiatrist Other:

Requested service: Outpatient therapy Medication management Assessment for Specialty Mental Health Services