# Child and Family Well-Being
# Parent Referral for Mental Health Treatment
# Assessment, Individual, Conjoint, or Group

Instructions for SW:

- Complete all pages - one form per individual and service.
- Review the Parent Therapy Flow Charts to ensure that a TERM referral for services is appropriate.
- Prior to referring a client for telehealth service delivery, the SW must review the Telehealth Criteria to ensure the client is appropriate for service.
- Confirm that there is not already a current authorization in place for the service.
- Complete all applicable fields. Blank fields and missing, outdated, or inaccurate information (i.e. CPT Code selection, missing zip code, incorrect DOB, Case ID) may lead to the referral being sent back as incomplete and will require resubmission to address errors or omissions before a search for a TERM provider can commence.
- If this is a resubmission, please alert the JELS clerk that it is a resubmission due to a previously returned authorization.

## A. PSW/PSS INFORMATION

**Date submitted to JELS Clerk:** **Region/Centralized Program:** <Select>

**Name of Assigned SW:** **Phone #:** **SW Email:** @sdcounty.ca.gov

**Assigned PSS Name:** **Phone #:** **PSS Email:** @sdcounty.ca.gov

**Assigned PSS Signature:** _____

If using electronic signature, please make sure you use a digital signature with date/time stamp. Please refer to the Digital Signatures Resource for information on how to digitally sign.

☐ Please check box if another PSS is signing on behalf of the assigned PSS and complete contact information below:

PSS Name **Phone #:** **PSS Email:** @sdcounty.ca.gov

**Note To Provider:** If you are unable to locate the SW with information provided above, call Hotline Records at (858) 514-6995 and provide code "BHS2021" to obtain SW information.

## B. CASE INFORMATION

☐ Voluntary ☐ Pre-Jurisdiction ☐ Court-Ordered Case Status: <Select> Next Court Date:

To avoid conflicts of interest, list full legal names and any alias used of the family members involved in the case plan and their relationship to child:

| Legal Name / Alias | Relationship to Child/Youth | Legal Name / Alias | Relationship to Child/Youth |
|---|---|---|---|
| 1. / | | 6. / | |
| 2. / | | 7. / | |
| 3. / | | 8. / | |
| 4. / | | 9. / | |
| 5. / | | 10. / | |

**CHECK ALL THAT APPLY:**

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☐ **A CHILD IN THIS CASE IS UNDER 3 YEARS OF AGE:** WIC 361.5 (a)(2) limits reunification services in these cases to 6 months. However, WIC 366.21(e) permits services to be extended up to six additional months if it can be shown that there is a substantial probability that the child will be returned to the parent/guardian by the end of that time.

☐ **Highly Vulnerable Child(ren) Case:** A higher-than-average possibility exists of serious re-injury or death to a child. Cases may include the following:

- Severe physical abuse, and serious non-accidental injuries to the head, face or torso in children age five (5) years or younger, or children who are developmentally delayed at a functional level of five years or younger.
- Child's parent or guardian caused the death of another child through abuse or neglect.
- Infant born to parents currently involved with CFWB or past involvement with CFWB and did not successfully reunify.

☐ **Parent had a previous CFWB case for: (check all that apply)**

☐ Domestic Violence ☐ Emotional Abuse ☐ General Neglect ☐ Severe Neglect ☐ Physical Abuse

- In previous case, parent <select>

**C. PARENT - REFERRAL INFORMATION** Please ensure you are entering parents LEGAL name as it appears on their case record. If alias is used or the name/DOB does not match the case record, referral will be returned.

**Legal Last Name:** **Legal First Name:** **Alias:**

**DOB:** **State ID #:** **Two Digit Person #:**

**Gender:** <select> **Pronoun(s):** <select> Comment**:**

**Relationship to Child/Youth:** <select> Comment:

**Language:** <select> **Ethnicity:** <select> If "Other," specify:

If service is to be provided in a language other than English, specify language: <select>

**Address:** **Phone Number:**

☐ Parent is homeless Zip code where parent is most frequently located:

**Date by which parent must demonstrate substantial progress in services :**

**Parent:** ☐ Denies allegations/true finding ☐ Accepts responsibility/true finding

**D. REFERRAL CATEGORY:** Check Group or Individual/Conjoint Treatment. Please reference Parent Flow Chart for appropriate modality.

☐ **GROUP TREATMENT - Select type of Group and CPT code for the Group Treatment**

☐ Domestic Violence (☐ offender **or** ☐ victim) CPT Code: <selection required>

☐ Sexual Abuse (☐ offending parent **or** ☐ non-protecting parent) CPT Code: <selection required>

☐ Child Abuse Group CPT Code: <selection required>

Parents referred for Group Treatment receive a one-time mental health assessment that determines suitability for group treatment. SW must follow up with the provider after the Initial Assessment to confirm eligibility.

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**Select the Treatment Modality and CPT Code:** <selection required>

☐ **INDIVIDUAL OR CONJOINT THERAPY – Select all the reasons that apply:**

☐ **Individual treatment to address the group therapy content**. Group facilitator determined that the parent is not appropriate for group treatment and recommending individual therapy in lieu of group to address the protective issue (i.e. domestic violence). If not sure, please consult with staff psychologist.
**Explain why this was recommended by group facilitator:**

☐ **Individual treatment to address mental health or Serious Mental Illness (SMI).** Parent's mental health directly relates to safety/risk factor(s), is identified as a need in the CANS (Caregiver/Resources Domain) and is a planned client service to meet the objective(s)/safety goal(s) in the Case Plan. For parents who suffer from documented history of SMI, a development of relapse prevention plan is indicated, **and** parent has a psychiatrist, is stable on medications and can engage in treatment.
**Describe the mental health/SMI concerns:**

☐ **Individual treatment because SW Suspects mental health concerns.** Parent does not have a diagnosed history of mental illness but self-reports symptoms of depression, self-reports suicidal or homicidal ideation, **and/or** other significant mental health concerns (e.g., severe hoarding, hearing voices) that impacts or interferes with parent's case plan progress.
**Describe the mental health concerns:**

☐ **Individual Treatment is recommended in consultation with PSS, CFWB Staff Psychologist, and/or other treatment providers (e.g., substance abuse counselor, group therapy facilitator):** :

☐ **Domestic Violence Conjoint Treatment** AFTER successfully completing DV offender or DV victim group therapy ☐ **Conjoint Treatment is recommended by Child's Therapist or SW** to facilitate child's therapeutic healing process. In Conjoint Therapy, client information pertains to the child/youth. Conjoint with the child ☐ Conjoint with the without the child ☐

☐ **Service is court ordered** Date of court order:

## E. REASONS FOR CFWB INVOLVEMENT All items in this section require a response for Optum to process the form.

**Date of the incident/range of time that resulted in current case:**

**Safety Threat(s) identified at onset of case (SDM Safety Assessment):** Check all that apply

☐ Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm.

☐ Child sexual abuse or sexual exploitation is suspected, and circumstances suggest that the child's safety may be of immediate concern.

☐ Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care resulting in serious harm or imminent danger of serious harm.

☐ The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

☐ Caregiver does not protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.

☐ Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, AND the nature of the injury suggests that the child's safety may be of immediate concern.

☐ The family refuses access to the child, or there is reason to believe that the family is about to flee.

☐ Domestic violence exists in the household and poses an imminent danger of serious harm to the child.

☐ Caregiver describes or speaks to the child in predominantly negative terms or acts toward or in the presence of the child in negative ways AND these actions result in severe psychological/emotional harm, resulting in imminent danger.

☐ Other (specify):

**Describe the incident incident(s) and safety/risk factors (i.e., protective issue(s)) that brought this family to CFWB's attention :**

**Harm Statement(s):**

**Danger Statement(s):**

**Safety Goal(s):**

**Describe the parent's Case Plan, participation and progress with meeting the Safety Goal(s):**

## F. WHAT IS THE CURRENT REASON FOR THERAPY REFERRAL Please reference Parent Flow Chart

Please summarize reason for parent being referral :

If parent has substance abuse treatment on their case plan or substance use is a complicating factor, provide information regarding progress in treatment, sobriety, drug test results that indicate they are ready to engage in therapeutic intervention on an outpatient basis; if unclear please consult with staff psychologist

## G. INFORMATION REQUIRED TO ESTABLISH PROVIDER MATCH

**Mental health services will be provided in**: ☐ San Diego County ☐ Other:

**Funding Source:** ☐ Medi-Cal: ☐ Yes County of San Diego Medi-Cal Number: Issue Date:

☐ CFWB Funds

☐ Parent has private insurance. Name of the insurance company

**Telehealth**

☐ Parent is willing and able to participate in tele-health **AND** they have the appropriate technology to participate. It is not a guarantee they will receive tele-health. (please reference the Telehealth Criteria guide.

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☐ Tele-therapy is specifically requested for this parent for the following reason(s):

☐ SW has reviewed the **Telehealth Criteria** and agree that all criteria can be met, and the client is appropriate for telehealth services

**Are you requesting reassignment from the previously assigned provider?** Yes ☐ No ☐

- If yes, what is the reason for the reassignment?
- If yes, what was the previous provider's name?
- If yes, do you want Optum to end the previous provider's authorization?

**TERM Provider requested** :
If specific provider requested, SW has confirmed with the provider that they are able to serve this parent: Yes ☐ No ☐

**Other agencies/professionals providing services to the child/youth involved, parent(s), or family system:** ☐ N/A

**Transportation issues/limitations:** ☐ N/A

**Scheduling preferences:**

**Past and/or current restraining orders (e.g., TRO, CPO, RO):**

**Has the parent threatened CFWB staff or others:** Yes ☐ No ☐ If yes, describe:

**Describe specific mental health concerns for the parent:**

**Current and past mental health diagnoses given by licensed mental health providers:**

**Current and past mental health treatments:**

**Current and past substance abuse/dependence:**

**Current and past medication(s):**

**Level of motivation/compliance regarding this service:**

## H. NON-TERM PROVIDER

Complete this section if requesting a non-TERM provider (check as many as applies)

☐ **Parent has needs that cannot be met through TERM panel. Specify below:**

Language:

Cultural:

Clinical:

Other:

☐ **SW requests approval of parent's current or past therapist to address protective issues:**

Name of therapist: Phone Number:

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E-mail Address:

☐ **Parent resides outside San Diego County but:** ☐ within California ☐ outside California

****ACTIONS REQUIRED FROM SW****

After completing the form:

- Submit the 04-176A(p) to Regional JELS Staff to submit to Optum TERM
- Send case records to the provider once they have been confirmed as per the Policy Manual: Mental Health Treatment to include court reports, court orders if relevant, psychological evaluations, prior mental health records, etc. Please confirmed delivery method of case information (mail or fax) DIRECTLY with the assigned provider before sending case documents.

Optum TERM will forward to provider with the CFWB authorization. For follow-up questions, please call Optum at 1-877-824-8376.