

# Pathways to Well-Being

## BHS/CWS Information Exchange

(Formerly: Progress Report to Child Welfare Services)

**BHS Information Request-** Fax form to Health Education Passport Office Assistant at Secure Child Welfare Services (CWS) region fax number below

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Central (619) 521-7325 | <input type="checkbox"/> North Central (858) 576-1032 | <input type="checkbox"/> Residential & EFC (619) 767-5221 |
| <input type="checkbox"/> East (619) 401-3792    | <input type="checkbox"/> North Coastal (760) 439-3008 | <input type="checkbox"/> Adoptions (858) 650-5832         |
| <input type="checkbox"/> South (619) 585-5174   | <input type="checkbox"/> North Inland (760) 740-3299  |   |

**CWS Information Request-** Please send correspondence via secure/encrypted electronic mail to the BHS Provider Directly. Contact information listed on page 2.

Client Name (Last Name/First Name)	Client DOB (mm/dd/yyyy)	Protective Services Worker (PSW)	PSW Phone Number
_____	_____	_____	_____

Provider may call **1-858-514-6995** for current CWS PSW contact information

- Initial** (within 30 days of determining eligibility)     **Update** (upon significant change or revised client plan)

**Choose one designation (Required):**

- Youth meets Enhanced Services (Subclass) criteria    **OR**     Youth is open to CWS (Class) but does not meet Enhanced Services (Subclass) criteria

Date of Pathways to Well-Being Eligibility Determination: \_\_\_\_\_

Updated as of 4/1/23: BHS Providers are required to share completed CANS tool and Diagnosis on Page 2 of form; Other elements are optional. CWS PSW is required to share current CANS Tool. All other elements are optional and can be shared upon request.

BHS Documents	CWS PSW Documents
<p><b>BHS is providing the following documents to CWS PSW (As Required below or Requested by CWS):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Required: Current completed CANS</b></li> <li><input type="checkbox"/> Most recent CFT Summary and Action plan (Only if CFT Meeting Facilitation Program wasn't utilized)</li> <li><input type="checkbox"/> Current Client Plan/Problem List (may be utilized in court reports)</li> <li><input type="checkbox"/> Current Client Assignment History from CCBH</li> <li><input type="checkbox"/> Discharge Summary</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p>Comments: _____</p>	<p><b>CWS PSW is providing the following documents to the BHS Provider (As Required below or Requested by BHS):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Required: Current completed CANS</b></li> <li><input type="checkbox"/> <b>Required for Foster Youth:</b> Consent for Examination and Treatment</li> <li><input type="checkbox"/> <b>Required for Foster Youth:</b> Authorization to Use or Disclose Protected Health Information</li> <li><input type="checkbox"/> Most recent CFT Summary and Action Plan</li> <li><input type="checkbox"/> Child Welfare Services Case Plan</li> <li><input type="checkbox"/> Detention Report</li> <li><input type="checkbox"/> Jurisdiction/Disposition Report</li> <li><input type="checkbox"/> Status Review Court Reports (every six months)</li> <li><input type="checkbox"/> No Contact List (if applicable)</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p>Comments: _____</p>

**Page 1 of this form is administrative and NOT included in court reports.**

Page 1

County of San Diego  
Health and Human Services Agency  
Child Welfare Services  
Behavioral Health Services

**Pathways to Well-Being**  
Information Exchange Form 04/01/2023

**Client:** \_\_\_\_\_

**Record Number:** \_\_\_\_\_

**Program:** \_\_\_\_\_

**Pathways to Well-Being**  
**BHS/CWS Information Exchange**  
 (Formerly: Progress Report to Child Welfare Services)

Client Name: \_\_\_\_\_

Client DOB: \_\_\_\_\_

Client Admission Date to BHS Program: \_\_\_\_\_

**BHS Legal Entity:** \_\_\_\_\_

**BHS Program Name:** \_\_\_\_\_

**BHS Provider:** \_\_\_\_\_

**BHS Provider Phone:** \_\_\_\_\_

**BHS Provider Email:** \_\_\_\_\_

**BHS Secure Fax:** \_\_\_\_\_

ICD-10 Code	DSM-V Diagnosis	Required to be shared with CWS PSW
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

BHS Provider Signature: \_\_\_\_\_ Credential: \_\_\_\_\_ Date: \_\_\_\_\_

**PSW may provide Page 2 of this form and the Client Plan/Problem List to the Court.**

County of San Diego Health and Human Services Agency Child Welfare Services Behavioral Health Services <b>Pathways to Well-Being</b> Information Exchange Form 04/01/2023	<b>Client:</b> _____ <b>Record Number:</b> _____ <b>Program:</b> _____
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