SUPPORTIVE HOUSING BEHAVIORAL HEALTH REFERRAL

PROGRAM INFORMATION

Date of Request: ☐

Housing Organization/Referral Source: ☐

Provider: ☐

Phone Number: ☐ Email: ☐

Reason For Referral: _____

_____

CLIENT INFORMATION

Client Name: ☐ Gender: ☐ F ☐ M ☐ Other

DOB: ☐ Age: ☐ SSN: ☐

Primary Language: ☐ Ethnicity: ☐ Race: ☐

Home Address: ☐ City: ☐ Zip Code: ☐

Phone: ☐

Parent/Guardian Name: ☐ Phone: ☐

Conservator Name: ☐ Phone: ☐

Client Informed of Referral: ☐ Yes ☐ No Date: ☐

Psychiatric/Substance Abuse Hospitalization in the last 12 months: ☐ Yes ☐ No

Date of Last EPS Admission: ☐

CHECK ALL THAT APPLY:

☐ Medication ☐ Individual /Family Therapy

☐ Group Therapy ☐ Case Management

TREATMENT NEEDS

CHECK ALL THAT APPLY:

☐ Depression/Mood ☐ Trauma ☐ Other _____

☐ Anxiety ☐ Psychosis

AREAS IMPAIRED:

☐ Social ☐ Family ☐ School ☐ Work ☐ Health ☐ Daily Living Skills

BARRIERS TO TREATMENT:

☐ Unhoused ☐ Transportation ☐ Language ☐ Substance Abuse ☐ Literacy

☐ Legal Status ☐ Other

☐ Additional Comments: _____

_____

_____

FINANCIAL INFORMATION

☐ Medi-Cal SUBSCRIBER ID #: ☐

☐ Medicare ID #: ☐

☐ No Insurance (Explain) _____

_____

_____

Once fully completed, submit referral via E-Mail to: bhss@communitysolutions.org.

SANTA CLARA COUNTY - MENTAL HEALTH DEPARTMENT
CONSENT / AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Client's Name:	**DOB:**
U-Code/ Program U-820 ICM Behavioral Health Supportive Services	**Unicare/ Avatar #**

I, ***(Name of Client)*** _____ and/or

(Parent/Legal Guardian/Conservator) _____ authorize

(Releasing Agency) **Community Solutions** to disclose to

(Receiving Agency/Person) X

Address: X

the following information with the knowledge such release discloses the fact that the named person has received mental health services.

The disclosure shall be limited to the following specific information *(Nature and amount of information to be disclosed; as limited as possible to accomplish the stated purpose or intended use):*

1. ☐ Diagnosis
2. ☐ Summary of psychological and psychiatric history
3. ☑ Medication information including the results of medical tests
4. ☑ Substance use information
5. ☐ Results of psychological and vocational tests
6. ☑ Legal Status
7. ☑ Educational assessment and behavioral reports (including school observations and educational testing)
8. ☑ HIV Status

9. ☐ **Other:** _____

The disclosure of the above-mentioned specific mental health information is required for evaluation, treatment or the following purpose *(indicate, as specific as possible, the purpose and use of the disclosure):* Care coordination

I understand that:

1) My mental health records are protected under the California Welfare and Institutions Code (WIC) and the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and cannot be disclosed without my written consent unless otherwise provided by the regulations. The exceptions are set forth in the *Notice of Privacy Practices*
2) I may revoke my consent by providing a written notice withdrawing my consent
3) If the program has already disclosed information in reliance on my consent, the program is not required to try to retrieve that information

I f not earlier revoked, this consent shall automatically terminate and expire on or as follows *(specify the date, event or condition, upon which this consent expires):* One year from date of signature.

Client's Signature X **Date:** X

Parent/Legal Guardian/Conservator's Signature _____ **Date:** _____

I certify that I have reviewed with the client or with his/her representative this *Consent to Release Confidential Health Information:*

☑ I find that the client has the capacity to give informed consent or the client's representative has the legal authority to act for the client. I hereby authorize the release of requested information.

☐ I find that the client does not have the capacity to give informed consent or the client's representative does not have or it is not clear if he/she has the legal authority to act for the client. I hereby do not authorize the release of the requested information.

Signature of Authorized Staff: X **Date:** X

☐ **Revoked – Date and Initial**_____