Behavioral Health Screening Form to Obtain Behavioral Health Assessment

Please complete and follow algorithm

*****If this is an emergency, e.g. suicide/homicide with plan, please call 911** Referral Date: _____

eConsult, if available as per health plan policy, may be used in lieu of this form to determine need for or obtain behavioral health assessment.

REFERRING PROVIDER INFORMATION

Please indicate where the *Receiving Clinician* should send the disposition of the urgent appointment:

Fax number: ( ) _____ To the attention of: _____

MEMBER INFORMATION

Patient Name: _____ (Last) _____ (First) Date of Birth: ____/____/____ ☐ M ☐ F

Medi-Cal # (CIN)/SSN: _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (_____) _____

Caregiver/Guardian: _____ Phone: (_____) _____

Referring Clinician: _____ Phone: (_____) _____

Primary Care Provider _____Phone: (_____) _____ Health Plan: _____

Behavioral Health Diagnoses (1) _____ (2) _____ (3) _____

Documents Included with Referral: ☐**Required consent completed** ☐MD notes ☐H&P ☐Assessment ☐Other: _____

Desired/existing behavioral health clinician/provider/program, if any: _____

List A - check all that apply:

- ☐Homelessness
- ☐Behavior problems (aggressive/self-destructive/assaultive)
- ☐Still symptomatic after 2 standard psychiatric med trials
- ☐Paranoid, hearing voices, seeing things, delusional
- ☐History of bipolar disorder or manic episode
- ☐Excessive emergency room visits or hospitalizations
- ☐Excessive truancy or failing school
- ☐Significant functional impairment in key roles, (e.g., work, home, self-care)
- ☐Substance and/or alcohol addiction and failed Screening and Brief Intervention (SBI)

List B - check all that apply if they occurred within the past 12 months:

☐>2 psychiatric hospitalizations ☐>2 incarcerations ☐Suicidal/homicidal ideation/behaviors without plan***

Referral algorithm based on checked boxes:

☐ *URGENT* 2 or more in list A and one in list B OR 2 or more in list B: **Fax form to DMH Urgent Line for urgent appointment at (562) 863-3971**

☐ *ROUTINE* 3 or more in list A and none in list B OR one in both lists: **Call DMH ACCESS Center for routine referral at (800) 854-7771**

☐ *HEALTH PLAN REFERRAL* 1-2 in list A and none in list B OR only one in list B: **Call health plan's behavioral health network for consultation or non-specialty mental health services referral**

☐ *SUD ONLY* Substance and/or alcohol addiction and failed SBI alone: **Call Substance Abuse Prevention & Control at (844) 804-7500**

Pertinent Current/Past Information

Current symptoms and impairments: _____

_____

Brief MH/SUD history: _____

Brief medical history/diagnosis: _____

Current Medication(s) & Dosage: _____

For Receiving Clinician Use ONLY

Instructions: **Fax this form to the number and person indicated at the top of the form**

*Referring provider to follow up with individual

Disposition of urgent appointment: ☐ **Attended** ☐ **Rescheduled** ☐ **Did Not Show*** ☐ **Declined*** ☐ **Unable to Accept Insurance Type***

Assigned Case Manager/MD/Therapist Name: _____ Phone: (_____) _____

Date disposition sent to referral source: _____/_____/_____ ☐ *Provider Communication Form* (MH 707) form attached

Instructions for the Behavioral Health Screening Form to Obtain Specialty Behavioral Health Assessment

If this is an emergency situation, including plan for suicide and/or homicide, please call 911

Abbreviations: **H&P**: History and Physical Exam **SBI:** Screening and Brief Intervention
MH/SUD: Mental Health and Substance Use Disorder

Explanations:

- *'Medi-Cal # (CIN)/SSN'*: Enter the Medi-Cal Number of the client. If the Medi-Cal Number is unavailable, enter the client's Social Security Number.
- '*Current Eligibility'*: Choose the appropriate eligibility from the drop down menu, i.e., Medicare, Private Insurance, Medi-Cal, Medi-Medi, Indigent, etc. **Note:** If the patient is a **Cal MediConnect** member, please enter: "CMC/ (Name of Health Plan)" and the CMC ID #.
- *'Caregiver/Guardian'*: Parents (for minor), conservator, etc.
- *'Required consent completed'*: The release of Protected Health Information may require a signed authorization from the client or his/her representative. Individuals completing this form are advised to refer to their agency policy when making this determination.
- *'Desired/Existing behavioral health clinician/provider/program'*: Complete this section if member/client or referral source prefers a specific program, clinician, or provider that would meet member's individual needs. If member/client is currently receiving services from a mental health program, clinician, or provider, please indicate name and contact information.
- *'Excessive ER visits or 911 calls'*: Check this box if the number of visits or calls exceeds what is reasonably expected as a result of the patient's general physical and behavioral health conditions.

Referring provider:

- If the Member/Client has an existing behavioral health clinician/provider or an open/active case in a program, please refer him/her directly to that treating source and send the written consent (or documentation of a verbal consent via phone), when required, with the screening form to the treating source.
- For referrals to County Department of Mental Health Urgent Line, please send the written consent (or documentation of verbal consent via phone), when required, with the screening form to the ACCESS Urgent Appointment Line via secure email at screener@dmh.lacounty.gov, fax to (562) 863-3971, or via eConsult and then call the DMH line at (855) 425-8141.
- For referrals to County Department of Mental Health ACCESS Center, please call or direct the client to call, the ACCESS Center at (800) 854-7771. The client may also directly call or walk into a specialty mental health clinic to request services. To find the nearest specialty mental health clinic, please use the Service Locator at http://lacdmh.lacounty.gov/appASPNET/ServiceLocator/.
- For referrals to the **health plan's behavioral health network**, please send the written consent (or documentation of verbal consent via phone), when required, with the screening form to the appropriate fax number or e-mail address and then call the phone number listed (see chart on Page 4 for contact information). **Note:** For **L.A. Care** providers with access to the **eConsult platform**, you are able to send the screening form via this platform.
- For referrals to County **Substance Abuse Prevention & Control** (SAPC), please send the written consent (or documentation of verbal consent via phone), when required, with the screening form to the provider referral fax at **(626) 458-7637** and then call the SAPC line at **(844) 804-7500**.

Receiving clinician:

- The "For Receiving Clinician Use ONLY" section must be completed and faxed to the number and person indicated at the top of the screening form as soon as the disposition of the initial appointment is known.
- The "Disposition of Initial Appointment" information must also be entered into the DMH Service Request Tracking System (SRTS) record.
- When required, the completed "Authorization to Exchange PHI" accompanying the "Behavioral Health Screening Form to Obtain Behavioral Health Assessment" permits a response to the referral source without further authorization.
- Complete and return the **Provider Communication Form** (MH 707) to the referring provider once the assessment has been completed. If it is determined that the individual's treatment need is better met at a different system of care/level of care, please refer and send the Provider Communication Form and completed assessment documents to the appropriate system of care/level of care.
- If the care is determined to be appropriately provided by the primary care physician, contact the health plan's behavioral health network.
- In the event of a disagreement as to the appropriate system of care/level of care, please forward the case to the appropriately identified individual responsible for dispute resolution within your system of care and continue with treatment while the decision is pending.
- If the Member/Client has requested services by himself/herself without a referral, please make sure to communicate with the identified primary care physician regarding the assessment outcome and/or disposition.

Health Plan Behavioral Health Network Contact Information

Medi-Cal Only Beneficiaries

Medi-Cal Managed Care Health Plan	Non-Specialty Behavioral Health Services Provider	Contact Information
Health Net	MHN	Fax: (855) 703-3268 Phone: (800) 675-6110 (Follow member prompts)
Health Net – Molina	Molina	Fax: (562) 499-6105 Phone: (888) 665-4621
L.A. Care	Beacon	Fax: (866) 422-3413 Phone: (877) 344-2858
L.A. Care – Anthem	Anthem	Fax: (855) 473-7902 (Attn: Medi-Cal BH) Email: Medi-CalBHUM@wellpoint.com Phone: (888) 831-2246 (Option 1 for BH, 2 for BH Intake)
L.A. Care – Care 1st	Beacon	Fax: Phone: (866) 422-3413(855) 765-9701
L.A. Care –Kaiser	Kaiser	**See below for Regional Offices:**

Bellflower Area – Downey/Norwalk	Fax: Phone:	(562) 657-2497 (562) 807-6200	San Fernando Valley – Woodland Hills	Fax: Phone:	(818) 592-3015 (855) 701-7955
Lancaster	Fax: Phone:	(661) 951-2999 (661) 951-0070	San Gabriel Valley – Baldwin Park/West Covina	Fax: Phone:	(626) 856-3010 (626) 960-4844
Los Angeles – Sunset	Fax: Phone:	(323) 783-4299 (323) 783-2600	South Bay	Fax: Phone:	(310) 517-3499 (310) 325-6543
Panorama City – Santa Clarita/Reseda	Fax: Phone:	(800) 700-8705 (818) 758-1200	West L.A.	Fax: Phone:	(323) 298-3119 (323) 298-3100

Cal MediConnect Beneficiaries

Cal MediConnect Health Plan	Non-Specialty Behavioral Health Services Provider	Contact Information
Care 1st	Beacon	Fax: (877) 752-3257 Email: cmc_Care1st@beaconhs.com Phone: (855) 765-9701
CareMore	Beacon	Fax: (877) 749-3734 Email: cmc_caremore@beaconhs.com Phone: (855) 371-8092
Health Net	MHN	Fax: (855) 703-3268 Email: MHN.CMC@MHN.COM Phone: (855) 464-3571
L.A. Care	Beacon	Fax: (800) 916-4102 Email: cmc_lacare@beaconhs.com Phone: (877) 344-2858
Molina	Molina	Fax: (562) 499-6105 Phone: (855) 665-4627