Health Plan of San Joaquin

Health Plan of San Joaquin/Mountain Valley Health Plan
Behavioral Health Services Referral Form

Mountain Valley Health Plan

Referral Date:_____ Member Name:_____ Medi-Cal CIN ID#:_____

DOB: _____ Parent/Guardian Name:_____ Preferred Language: _____

Phone: _____ (home); _____ (parent/guardian's cell); _____ (member's cell)

Member address: _____

Does the minor 12 and older have capacity to give consent to services? ☐ Yes ☐ No If no, please explain _____

Best day/time to reach the member: _____ Best day/time to reach the parent/guardian: _____

PCP Clinic/Agency: _____ Name of PCP: _____ PCP Phone #: _____

To receive a confirmation of this referral's outcome, please check the box below noting preferred method and contact details:

☐ Email address: _____ ☐ Fax Number: _____

☐ **Please check** to confirm member eligibility was verified

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Name of Requestor _____

Requestor (one request per referral form)

☐ PCP ☐ BH Provider ☐Regional Center ☐ Other _____

☐**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Health Plan's network of providers when their needs are outside the PCP scope of practice. Health Plan can coordinate member care with county mental health. *Fax:* ***1-209-762-4761*** *OR secure email: BHCM@hpsj.com*

☐**Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with a Licensed Psychologist or Physician order requesting ABA services. *Fax:* ***1-209-762-4760*** *OR secure email: BHTReferral@hpsj.com*

☐**Referral for Psychological or Neuropsychological testing:** Refer members to psychological/neuropsychological testing via Health Plan's network of providers when their needs are outside the PCP scope of practice. Health Plan can coordinate member care with county mental health. *Fax:* ***1-209-762-4760*** *OR secure email: BHTReferral@hpsj.com*

Request Reason (check all that apply):

Symptoms:

☐ Depression
☐ Poor self-care due to mental health
☐ Psychosis (auditory/visual hallucinations, delusional)
☐ Adverse Childhood experiences (ACEs)
☐ Perinatal depression/anxiety
☐ Violence/Aggressive behavior
☐ Psychological testing
☐ Neuropsychological testing
☐ PTSD/Trauma
☐ Abuse/CPS
☐ Chronic Pain
☐ Anxiety
☐ Substance use type: _____
☐ Other BH symptoms: _____

Impairments:

☐Difficult/Unable to complete ADLs ☐Difficulties maintaining relationships ☐Legal/CPS
☐Difficult/Unable to go to work/school ☐Other:_____
Medications (list below or send medication list with this form):
_____

Motivation for Services (check all that apply)

☐ Member (or guardian) has been informed for referral to Health Plan's Behavioral Health Services
☐ Member wants services for self (or dependent)
☐ Member is unsure or ambivalent about services for self (or dependent)
☐ If applicable, Patient has completed a PHQ-2/PHQ-9, Score _____

For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.

Health Plan of San Joaquin

Authorization for Health Plan of San Joaquin/ Mountain Valley Health Plan to Release Confidential Information

Mountain Valley Health Plan

Important: By completing all sections of this form you allow Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") to disclose health care information to the individuals you identify for up to one year. Completion of this form allows Health Plan to share information with your family, providers, legal representative, or **anyone** that you wish to have access to this information. Please fill in all sections as incomplete forms may be returned.

Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible. The purpose of sending the health information to your doctor is to assist in identifying any follow-up medical care that may be needed. To allow us the ability to send your health information to your doctor, complete and sign the release of information below. We will only send information that pertains to your care.

SECTION 1: IDENTIFY THE PERSON WHOSE INFORMATION IS TO BE RELEASED

I, _____ **(Member Name)** authorize Health Plan to disclose my health care information as described below.

Additional Member Identifying Information Member ID#: _____ DOB: _____

Phone Number: _____ Name of Health Plan: _____

SECTION 2: IDENTIFY THE PERSON, PROVIDER, OR ENTITY TO RECEIVE THE INFORMATION

Print the Name(s) of person or organization who will be receiving my information and contact information (if known):

_____

_____

_____

Phone Number of the Recipient: _____

SECTION 3: IDENTIFY THE REASON WHY THE INFORMATION SHOULD BE RELEASED (THE REASON MAY BE "AT MY REQUEST")

Reason: _____

If known: ☐Care Coordination/Management ☐Claim Assistance ☐Quality of Care Review

☐Other (Please explain reason): _____

SECTION 4: IDENTIFY WHAT HEALTH INFORMATION MAY BE RELEASED

BY INITIALING the following items, you are authorizing Health Plan to release the following specific types of information to the person(s) identified in Section 2 above:

_____Mental health information and/or records **(INITIALS REQUIRED!)**

_____Alcohol or substance use information and/or records **(INITIALS REQUIRED!)**

____ HIV/AIDS related information and/or records **(INITIALS REQUIRED!)**

____ Other health information, please specify **(INITIALS REQUIRED!)**: _____

Special instructions, if any (you may specify provider, date span, service type, etc.): _____

_____

SECTION 5: IDENTIFY HOW LONG YOU WOULD LIKE THIS AUTHORIZATION TO LAST (up to one year)

This authorization shall be in force and effect **for one year** or until I revoke it, in the manner described below or until **(insert expiration date or event**) _____ *(whichever is shorter)*.

SECTION 6: YOUR RIGHTS:

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that Health Plan has already sent to the recipient***.

Please note that if you have authorized the release of ONLY alcohol or substance abuse treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

_____ _____

Signature of the Member or the Member's Legally Authorized Representative* Date

_____

Print Name

**** NOTE: If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc.* A financial or business power of attorney is NOT sufficient.**

Please contact the phone number for behavioral health, mental health, or substance use services on your medical ID card with any questions or to determine where to mail or fax your request.