Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary
For San Francisco Health Plan Medi-Cal Members

MEMBER INFO

Patient Name: _____ Date of Birth: ___/____/____

Preferred Name: _____ ☐M ☐F ☐T ☐O

Medi-Cal # (CIN): _____ San Francisco Health Plan #: _____

Language/cultural requirements (client or caregiver): _____

Address:_____City:_____Zip:_____Phone:(____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Referring Clinician: _____ Phone: (____) _____

Primary Care Provider _____ Phone: (____) _____

DSM diagnosis, if known: (1) _____(2) _____Consent to share information received (verbal/written): ☐ Yes ☐ No

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

Is provisional diagnosis/diagnosis an included diagnosis for MHP services (page 2) ☐ Yes ☐ No ☐ Unsure

List A (check all that apply)	List B (Check all that apply)	List C
☐ Persistent symptoms & impairments after 2 recent medication trials ☐ Multiple co-morbid health and mental health conditions ☐ Behavior problems (aggressive/self-destructive/assaultive/extreme isolation) ☐ Excessive ED visits or 911 calls ☐ Bipolar disorder ☐ Trauma/recent loss/significant life stressors ☐ Depressive symptoms ☐ Anxiety symptoms ☐ Homelessness/housing instability resulting from mental health condition ☐ ADHD symptoms ☐ Lack of diagnostic clarity	☐ 2 or more psychiatric hospitalizations within 12 months ☐ Functionally significant, non-substance induced paranoia, delusions, hallucinations, mania, dissociative symptoms, depression, personality disorder ☐ Suicidal/Homicidal preoccupation with plan or behavior in past year ☐ Transitional Age Youth with prodromal psychotic symptoms ☐ Eating disorder with medical complications (with medical condition being treated by Health Plan)	☐ Substance use disorder not responding to SBI (screening & brief intervention at primary care)

	Referral Algorithm	
1	**PCP** to manage medications with the option to refer to **Beacon** for **therapy** and/or **PCP decision support** **Fax: (866) 422-3413,** Phone: (855)371-8117	☐1-2 in List A and none in List B
2	Refer to **Beacon** for brief therapy and/or psychiatry **Fax: (877) 321-1787)** Phone: (855)371-8117	☐3 in list A and none in list B OR ☐Diagnosis excluded from county MHP
3	Refer to **San Francisco Behavioral Health Services (ACCESS), Phone: (415) 255-3737** Fax: (415) 255-3629	☐ 4 or more in list A OR ☐1 or more in list B
4	Refer to **San Francisco County Substance Use Services (TAP) Phone: (415) 503-4730- Walk in between 8am-4pm 1380 Howard Street**	☐1 from list C

Provider completing screening: _____ Phone: (____) _____

Signature _____ Date _____

☐ PCP ☐ MFT/LCSW ☐ NP ☐ Psychiatrist ☐ Other _____

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Request:

☐ Step-down from County level of care to Managed Care Plan for service (therapy and/or medication management)
☐ Referral to County for assessment due to significant impairment
☐ Registration requested for services (with submitting provider)
☐ Referral for services to an in-network provider (Beacon to contact member to provide referrals)
☐ Member meets criteria for assessment with SFBHS but is being managed at MCP level of care
- *Only applicable if member is refusing services at SFBHS and utilizing services at a mild to moderate level of care*

Requested service ☐ Outpatient therapy ☐ Medication management ☐ Assessment for Specialty Mental Health Services

Additional Information, if necessary:

Current symptoms and degree of impairment: _____

_____

Brief psychiatric and substance abuse history: _____ __

_____

Brief medical history: _____

Select documents attached: ☐ consent to share information ☐ medication list ☐ H&P ☐ Assessment

☐ other clinical data

For Informational Purposes ONLY

Diagnostic ranges that qualify an individual for County Mental Health Services [Title 9 California Code of Regulations Section 1830.205

1. Pervasive developmental disorders, except autistic disorders;
2. Disruptive behavior and attention deficit disorders;
3. Feeding and eating disorders of infancy and early childhood;
4. Elimination disorders;
5. Other disorders of infancy, childhood, or adolescence;
6. Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition;
7. Mood disorders, except mood disorders due to a general medical condition;
8. Anxiety disorders, except anxiety disorders due to a general medical condition;
9. Somatoform disorders;
10. Factitious disorders;
11. Dissociative disorders;
12. Paraphilias;
13. Gender Identity Disorder;
14. Eating disorders;
15. Impulse control disorders not elsewhere classified;
16. Adjustment disorders;
17. Personality disorders, excluding antisocial personality disorder;
18. Medication-induced movement disorders related to other included diagnoses

As a result of one or more of diagnosed mental disorder(s) above, the patient must have a **significant impairment or probability of significant deterioration** in an important area of life functioning such as: work/school; family/ peer relationships; housing: self-care; etc.

For Receiving Clinician Use ONLY

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

Date communicated assessment outcome with referral source: _____