# Child 0 - 5 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

## For San Francisco Health Plan (SFHP) Medi-Cal Members

### *MEMBER INFO*

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

Preferred Name: ____________________________________________ ☐ M ☐ F ☐ T ☐ O

Medi-Cal # (CIN): ______________________ SFHP ID #: _______________________

Language/cultural requirements (client or caregiver): ______________________________________________

Address: _________________________________ City: ________________________ Zip: _________ Phone: (_____) ___________________

**Caregiver/Guardian:** __________________________________________________ Phone: (_____) ___________________

Individual providing information: ______________________________________ 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** ☐ Yes ☐ No ☐ Unsure

| List A (check all that apply) | List B (Check all that apply) | List C |
|---|---|---|
| ☐ **Impulsivity/hyperactivity** | ☐ Significant Parent/Child attachment concerns | ☐ Currently in foster care placement |
| ☐ **Withdrawn/Isolative** | ☐ Child age 0-3 with at least 2 items from List A | |
| ☐ **Excessive crying; difficult to soothe** | ☐ Aggression and/or frequent tantrums | |
| ☐ **Significant family stressors** * | ☐ Neglect/Abuse | |
| ☐ **CPS report in the last 6 months** | ☐ Self-Harm: frequent head banging/risky behavior | |
| ☐ **Limited receptive and expressive communication skills** | ☐ Trauma (describe:______________________________) | |
| ☐ **Sleep Concerns: difficulty falling asleep, night waking, nightmares** | ☐ At risk of losing home, child care or preschool placement due to mental health/behavior issues | |
| ☐ **Peer relationship issues - little enjoyment or interest in peers; self-isolating; frequent conflict with peers** | ☐ Separation from/loss of primary caregiver | |
| ☐ **Failure to thrive/feeding difficulties** | ☐ Depression/anxiety | |
| ☐ **Elimination difficulties** | ☐ Diagnostic uncertainty | |
| ☐ **Learning Difficulties** | | |
| ☐ **Sexualized Behaviors** | | |
| ☐ **Serious medical issues/other disabilities** | | |
| ☐ **May not progress developmentally as individually appropriate without mental health intervention** | | |

*** Significant family stressors:** Caretaker(s) with serious physical, mental health, substance use disorders or developmental disabilities, domestic violence, unstable housing, homelessness, environmental stressors, marital discord/divorce, or loss of caregiver

| | Referral Algorithm | |
|---|---|---|
| 1 | **PCP** to manage with the option to refer to **Beacon** for **therapy** and/or **medication decision support**<br>**Fax: (866) 422-3413,** Phone: (855)371-8117 | ☐1 in List A and none in List B |
| 2 | Refer to **Beacon** for brief therapy and/or psychiatry<br>**Fax: (877) 321-1787)** Phone: (855)371-8117 | ☐2 in list A and none in List B OR<br>☐Diagnosis excluded from county MHP (see page 2) |
| 3 | Refer to **San Francisco Behavioral Health Services (ACCESS)**,<br>**Phone: (415) 255-3737** Fax: (415) 255-3629 | ☐ 3 or more in List A OR<br>☐1 or more in List B |
| 4 | Refer to **Beacon**. **Fax: (855) 371-8113,** Phone: (855) 371-8117.<br>**Beacon** to contact FCMC **at fcs.lookup@sfgov.org** to coordinate care. | ☐ 1 in List C with 2 or less in List A and none in List B<br>☐ 1 in List C with a diagnosis excluded from county MHP (but a need for mental health services) |

# Child 0 - 5 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

## For San Francisco Health Plan (SFHP) Medi-Cal Members

**Print name of provider completing screening:** ______________________________

Signature ______________________________ Date ____________

☐ PCP ☐ MFT/LCSW ☐ NP ☐ Psychiatrist ☐ Psychologist ☐ Other ______________

**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
☐ Referral for non-specialty mental health services
☐ Registration requested for services (with submitting provider)

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

***Additional Information, if necessary:***

Current symptoms and impairments: ______________________________

______________________________

Brief Patient history: ______________________________

______________________________

Brief psychiatric history: ______________________________

______________________________

Brief medical history: ______________________________

Select documents attached: ☐ Consent to share information ☐ Medication list ☐ History & Physical

☐ 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: ______________________________