Child 6 – 17 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	List D
☐ Impulsivity/hyperactivity ☐ Trauma/recent loss ☐ Withdrawn/Isolative ☐ Mild-moderate depression/anxiety ☐ Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) ☐ Significant family stressors ***** ☐ CPS report in the last 6 months ☐ Difficulty developing and sustaining peer relationships ☐ Eating disorder without medical complications ☐ Court dependent or ward of court ☐ May not progress developmentally as individually appropriate without mental health intervention ☐ Juvenile probation supervision with current placement order ☐ Substance use (not as primary diagnosis) ☐ Gender Dysphoria	☐ 1 or more psychiatric hospitalization(s) in past year ☐ Suicidal/homicidal preoccupations or behaviors in past year ☐ Self-injurious behaviors ☐ Excessive truancy or failing school ☐ Paranoia, delusions, hallucinations, hearing voices ☐ Functionally significant depression/anxiety* ☐ Eating disorder with medical complications (with medical condition being treated by Health Plan) ☐ At risk of losing home, or school placement due to mental health issues	☐ Substance abuse as primary diagnosis	☐ Currently in foster care placement

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

* **Functionally significant depression/anxiety**: significant impairments related to independent living skills, social relations or education

	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 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	☐2 in list A and none in List B OR ☐Diagnosis excluded from county MHP (see page 2)
3	Refer to **San Francisco Behavioral Health Services (ACCESS), Phone: (415) 255-3737** Fax: (415) 255-3629	☐ 3 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 in List C
5	Refer to **Beacon**. **Fax: (855) 371-8113,** Phone: (855) 371-8117. **Beacon** to contact FCMC at **fcs.lookup@sfgov.org** to coordinate care.	☐ 1 in List D with 2 or less in List A and none in List B ☐ 1 in List D with a diagnosis excluded from county MHP (but a need for mental health services)

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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: _____

IEP in Place: ☐ No ☐ Yes If yes, school _____
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: _____