Assessment, Individual, Conjoint, or Group Treatment Referral Form
Child Welfare Services

One client per Referral Form - SW to complete all pages

PSW/PSS INFORMATION

Date submitted to Optum:

Name of SW: Phone #: SW Email: Region/Centralized Program: <select>

PSS Name: PSS Phone #: PSS Email:

PSS Signature: _____

NOTE to provider: If you are unable to locate the SW with information provided above, call (858) 514-6995.

CASE INFORMATION

☐ Voluntary ☐ Pre-Jurisdiction ☐ Court-Ordered Case Status: <select> Next Court Date:

Full legal names of family involved in case plan and relationship to child (to avoid conflicts of interest):

CHECK ALL THAT APPLY:

☐ **A CHILD IN THIS CASE IS UNDER 3 YEARS OF AGE:** W&I Code 361.5 (a)(2) limits reunification services in these cases to 6 months. However, W&IC 366.21(e) permits services to be extended up to six additional months if it can be shown that there is a substantial probability that the child will be returned to the parent/guardian by the end of that time.

☐ **Highly Vulnerable Child(ren) Case:** A higher-than-average possibility exists of serious re-injury or death to a child. Case may include:

- severe physical abuse, and serious non-accidental injuries to the head, face or torso in children age five years or younger, or children who are developmentally delayed at a functional level of five years or younger.
- child's parent or guardian caused the death of another child through abuse or neglect
- infant born to parents currently involved with CWS or pas involvement with CWS and did not successfully reunify

☐ **This client has had a previous CWS case for** <select> **and** <select>
In previous case, this client ☐ reunified or ☐ failed to reunify

CLIENT INFORMATION

Name of Client: Gender: <select> DOB: State ID #: Two Digit Person #:

Funding Source: <select> County of San Diego Medi-Cal Number: Issue Date:

If client has private insurance, please provide the name of the insurance company:

Client's Relationship to Child: <select> Comments:

All additional service recipients, if requesting conjoint therapy:

If service is to be provided in a language other than English, Language: <select>

If client is a child/youth, indicate language of their parent/caregiver: <select>

Ethnicity: <select> If "Other," please specify:

Client's/Caregiver's Name and Address (including facility name, if any): **(Please note if the client is homeless, you should note the zip code where they most frequently are located)**

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Client's/Caregiver's Phone Number:

Reasons for CWS Involvement

Please note, all of the items in this section require a response for the form to be processed:

Date of the incident that resulted in current case:

Describe the incident that brought this family to CWS' attention:

What Safety Threats were identified at onset of case (from SDM Safety Assessment):

What is the Harm Statement:

What is the Danger Statement:

What are the Safety Goals for this family:

Describe what is going on in the case right now, for the client being referred:

Describe this client's Case Plan participation and progress with meeting Safety Goals:

Information Required to Establish Provider Match

Are you **requesting reassignment** from the previously assigned provider? Please note yes or no:

- If yes, what is the reason for the reassignment:
- If yes, what was the previous provider's name?
- If yes, do you want us to end the previous provider's authorization?

TERM Provider requested (optional – SW may request a provider):
If specific provider requested, have you confirmed with the provider that they are able to serve this client?
(Please note that TERM cannot provide the client's name to the provider, so knowing you have already spoken to them allows the provider to decide if they want to accept this client or not.)

If client is a **parent**, describe specific mental health concerns:

Therapeutic Intervention requested for **child**: <select> **NOTE:** SW **does not** have to select a therapeutic intervention.

Other agencies/professionals providing services to client and/or their family system (if none, write N/A):

Transportation issues/limitations (<u>if no limitations, write N/A</u>):

Scheduling preferences (evenings/weekends only, etc.): If in-home therapy is needed for this client, reason for in-home therapy: Past and/or current restraining orders (e.g. TRO's, CPO's, RO's):

Has the parent threatened CWS staff or others:

Mental health diagnoses given by **licensed mental health providers** (not client's self-report or non-licensed professional's opinion) in the past:

Current and past mental health treatments (e.g. medications, inpatient hospitalizations, outpatient treatment):

Current and past substance abuse/dependence including drug(s) of choice, current use, past treatments, and response to treatment:

Level of motivation/compliance regarding this service:

Medication(s) - past and current:

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School aged child:

Current grade School

IEP? ☐ Yes ☐ No If Yes, What is the reason for the child's IEP?

COMPLETE THIS SECTION FOR CHILD/ADOLESCENT REFERRAL

REASON FOR REFERRAL:

☐ **CANS -** Is this referral for the child due to a CANS score of 1, 2 or 3 on any item on the Child Behavioral/Emotional Needs Domain, enter date of CANS/CFT and attach a copy of the CANS to this referral.

☐ If child only scored 0 or 1 in this section - The provider will complete a Mental Health Assessment to determine if additional services are needed.

☐ The child scored a 2 or 3 in this section – Child will be referred to individual therapy.

***If a prior CANS referral was made, what was the date of the first referral?

☐ **Serious Emotional Damage.** A petition has been, or will be, filed under Section 300(c) (Serious Emotional Damage) and CWS would like a licensed mental health professional to assess for the effects of abuse and/or neglect on the child.

☐ **Child is a sexual abuse victim or has witnessed or otherwise been exposed to age-inappropriate or adult sexual behavior.**

☐ **Emotional Abuse** due to exposure to domestic violence.

☐ **Severe Emotional Abuse, Physical Abuse, and/or Neglect.** Child may have been tortured. Specific allegations/true findings :

☐ **Emotional Abuse, Physical Abuse, and/or Physical Neglect.** Child is either living with biological parent or with substitute caregiver (e.g. foster parent, NREFM) and there are behavioral and/or emotional issues.

☐ **Adoption/Termination of parental rights.** The child will not be reunifying with his/her parent(s). An opportunity to process grief/loss issues is appropriate.

☐ **Child recently changed placement.** An opportunity to process grief/loss issues is appropriate.

☐ **Prior therapist terminated services prior to the completion of therapy.**

☐ **The child exhibits significant behavioral concerns:**

- ☐ Self-harming behaviors and/or suicidal ideation, plan, and/or past suicide attempts
- ☐ Sexual Behavior Problems (SBP)
- ☐ **VERIFIED** willful cruelty to animals
- ☐ Physical aggression toward peers and/or caregivers.

☐ **Conjoint Therapy** is recommended by Child's Therapist or SW to facilitate child's therapeutic healing process.

If contrary to a CWS recommendation, the service being requested was court ordered. Date of court order:

Select the Treatment Modality and CPT Code: <select>

For conjoint treatment referrals:

Mother ☐ has ☐ has not **(check one)** successfully completed group treatment **(list completed services):**

☐ N/A

Father ☐ has ☐ has not **(check one)** successfully completed group treatment **(list completed services):**

☐ N/A

Child/Adolescent's therapist states child is clinically ready for conjoint therapy ☐ Yes ☐ No ☐ N/A

COMPLETE THIS SECTION FOR PARENT REFERRAL

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Date by which parent must demonstrate substantial progress in services:
Client: ☐ Denies allegations/true finding
☐ Accepts responsibility/true finding

GROUP TREATMENT - Select type of Group and CPT code for the Group Treatment (
☐ Domestic Violence (☐ offender **or** ☐ victim) / CPT Code: <select>
☐ Sexual Abuse (☐ offending parent **or** ☐ non-protecting parent) /CPT Code: <select>
☐ Child Physical Abuse Group /CPT Code: /CPT Code: <select>
Clients referred for Group Treatment receive a one-time assessment for suitability for the group. SW must follow up with the provider after the Initial Assessment to confirm eligibility.

OR

INDIVIDUAL OR CONJOINT THERAPY – Select all of the Reasons that apply:
☐ **Individual Treatment Recommended by Group Facilitator because:**
- ☐ Parent has other significant emotional issues/concerns *pertaining to the protective issues* that make him/her inappropriate for group at this time or that require additional, individual treatment to address
- ☐ Parent's behavior is inappropriate or otherwise disruptive to the group

☐ **Individual Treatment to Address Serious Mental Illness.** Parent has a documented history of serious mental illness (SMI). Development of relapse prevention plan is indicated.
☐ **Individual Treatment because SW Suspects Mental Health Concerns.** Parent does not have a diagnosed history of mental illness but self-reports depression or other significant mental health concerns that are not due to CWS involvement, self-reports suicidal or homicidal ideation **and/or** other mental health concerns (e.g., severe hoarding, hearing voices) that directly impact parent's ability to safely parent.
Describe the mental health concerns here:
☐ **Substance Abuse Treatment (SAT) Recommendation.** Parent active to SAT; treatment recommendations include individual therapy for these specific reasons/issues:
☐ **Domestic Violence Conjoint Treatment. AFTER** successfully completing DV offender or DV victim group therapy. NOTE: Conjoint Therapy is NOT a required case plan element in domestic violence cases.
☐ **Conjoint Treatment is Recommended by Child's Therapist or SW.** to facilitate child's therapeutic healing process.

If contrary to a CWS recommendation, the service being requested was court ordered. Date of court order:

Select the Treatment Modality and CPT Code: <select> **For conjoint treatment referrals:**
Mother ☐ has ☐ has not **(check one)** successfully completed group treatment **(list completed services):**
☐ N/A

Father ☐ has ☐ has not **(check one)** successfully completed group treatment **(list completed services):**
☐ N/A

Therapist states client is clinically ready for conjoint therapy ☐ Yes ☐ No ☐ N/A

****ACTION REQUIRED BY SW****

Submit the 04-176A to Regional JELS Staff to submit to Optum TERM. Attach the most recent CANS to the referral form.

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Optum TERM will forward to provider with the CWS authorization. For follow-up questions, please call Optum at 1-877-824-8376

Send case records to the provider as per the Policy Manual: Mental Health Treatment to include court reports, court orders if relevant, psychological evaluations, prior mental health records, etc.