Healthy Families Mental Health Response Form

Section 1:

Enrollee's Name: _____ DOB: _____

SSN/Healthy Families Plan Membership #: _____ County Identifier #: _____

Parent/Guardian Name: _____ Phone: _____

Address: _____

Section 2:

Enrollee's Healthy Families Health Plan: _____ Referral Date: _____

Referring Party: _____ FAX: _____

☐ Designated Health Plan (HP) Representative (e.g., Care Coordinator, Case Manager, etc.)

☐ HP Primary Care Provider ☐ HP Mental Health Provider ☐ HP Alcohol & Other Drug (AOD) Service Provide

Section 3:

ENROLLEE ELIGIBILITY

☐ The enrollee meets the criteria for services for children with Severe Emotional Disturbance (W&I Code 5600.3)

☐ The enrollee does not meet the criteria for children with Severe Emotional Disturbance (W&I Code 5600.3)

☐ Axis I Diagnosis (REQUIRED*):* _____

Section 4:

CRITERIA ESTABLISHING ENROLLEE'S ELIGIBILITY FOR SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE (SED)

The enrollee met the criteria in one or more of the following three categories:

A. As a result of a mental disorder the enrollee has substantial impairment in at least two of the following areas:
   - ☐ Self-care
   - ☐ School functioning
   - ☐ Family relationships
   - ☐ Ability to function in the community

   And one of the following conditions occur:

   - ☐ The enrollee is at risk for removal from his/her home
   - ☐ The enrollee has been removed from his/her home
   - ☐ The mental disorder/impairments have been present for six months, or are likely to continue for more than one year without treatment

B. The enrollee displays: psychotic features, risk of suicide, risk of violence due to mental disorder

C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Section 5:

DISPOSITION
(letters A - D *must* be completed)

A. Refer back to Health Plan for basic Mental Health Services ☐ Yes ☐ No

B. Refer back to Health Plan for basic Alcohol and Other Drug Services ☐ Yes ☐ No

C. County Mental Health Department to provide services ☐ Yes ☐ No

D. Refer to another service ☐ Yes ☐ No

If "Yes," list service(s): _____

_____

Additional Comments: _____

_____

_____

_____

_____

Section 6:

Evaluating Clinician Name (printed): _____ Phone: _____

Agency Name: _____

Address: _____

Signature: _____ Date: _____