ATTACHMENT I

San Bernardino County
Department of Behavioral Health

Guidelines for Completing Referral Summary for Referral to Managed Care Plan

STEP 1: Complete the first section, providing beneficiary's identifying information. For hand-written forms, please write legibly. Please verify accurate Managed Care Plan (MCP) before submitting.

Beneficiary Name: _____

Beneficiary DOB: _____ **Age:** ___

Preferred language: _____

Assigned MCP: IEHP _____ **Health Net** _____ **Kaiser** _____ **Molina** _____

STEP 2: Provide information on Risk Criteria, confirming that beneficiary ***has not*** experienced any of the following situations ***within 12 months*** prior to the date of submitting the Referral Summary. A review of chart documentation (e.g., Interdisciplinary Notes) and Medi-Cal billings should be conducted to guide completion of this section.

REMINDER: ***If beneficiary is in DBH related housing, discuss client's status with Supervisor prior to submitting.***

Risk Criteria	**Not within 12 months**
Psychiatric inpatient hospitalization.	☐
Use of DBH crisis services (i.e., Clinic, CCRT or CWIC), per beneficiary/caretaker report and billing review.	☐
Encounters with Law Enforcement or visits to Hospital Emergency Departments for a psychiatric emergency, per beneficiary/caretaker report.	☐
No self-injurious or high risk behavior without regard for personal safety or the safety of others, per beneficiary/caretaker report.	☐

NOTE: ***If any of the boxes above are not checked, consult with Supervisor before proceeding with referral submission.***

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STEP 3: *Provide information regarding beneficiary's current level of functioning. Provide one or more **specific**, **observable**, **behavioral** examples that demonstrates clinical stability, and that any identified needs/challenges **do not** currently cause **significant impairment** in beneficiary's daily life. Some examples provided to help guide completion of this step.*

Area of Functioning	**Explanation** (Include brief description of strengths and needs)
Health/Self-care/Housing	*(e.g., beneficiary attends medical and mental health appointments as scheduled, beneficiary is able to complete basic self-care tasks such as hygiene maintenance and medication compliance, beneficiary lives independently in an apartment and/or current housing situation is stable)*
Occupation/Education	*(e.g., beneficiary has held part-time job for past 12 months and has good attendance; beneficiary receives SSI)*
Legal	*(e.g., beneficiary has met all requirements related to their terms of Probation or has maintained significant progress with their terms of probation)* *(e.g., beneficiary has met all requirements or has maintained significant progress related to his/her Children & Family Services plan and/or child(ren) have been returned to his/her care)*
Money Management	*(e.g., beneficiary is able to manage finances independently, including paying rent on time; beneficiary continues to utilize SSI funding)*
Interpersonal/Social	*(e.g., beneficiary has joined a local support group and attends regularly, beneficiary has reconnected with his/her sibling who is a source of support)*

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Step 4: Provide beneficiary's current diagnosis, including ICD-10 Code and ICD-10 Diagnostic Label.

Discharge Diagnosis	
ICD-10 Code/DSM-5	**Diagnostic Label**
_____	_____
_____	_____
_____	_____

Step 5: Confirm that beneficiary has agreed with the recommendation to refer to the MCP.

Has Beneficiary agreed to referral to MCP?

Yes _____

No _____

NOTE: *If "Yes" is marked in the above section, confirm that the recommendation and beneficiary's agreement are noted in the chart (e.g, Interdisciplinary Notes).*

If "No" is marked in the above section, refer to "Tier Transition Protocol (QM6040)" for guidance on next steps, before proceeding with submission of referral.

Step 6: Complete Signature and Date section.

NOTE: *This should be the name of the clinic staff member filling out the Referral Summary*.

Signature of Person Completing Referral Summary

_____

Printed Name of Person Completing Referral Summary

_____

Date Referral Summary Completed

_____

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Step 7: Compile and attach all necessary supporting documentation. Please place check mark by each item to confirm or verify that requested documents are included in the packet. If packet is missing any document(s), please discuss with supervisor.

Attachments:

_____ **Signed Authorization for Release of Protected Health Information (PHI) to release PHI to MCP**

_____ **ICT Referral Form**

_____ **Outpatient medication record for past 12 months, if applicable**

_____ **Alert Sheet**

_____ **Three most recent Psychiatrist notes, if applicable**

Step 8: **Provide Referral Summary and supporting documentation to Program Manager, or designee, for final review and submission to the appropriate MCP liaison.**

REMINDER: *DBH Clinic must continue to provide services until the clinic has verified that the beneficiary has been successfully engaged in services with MCP Provider. Please check with clinic/supervisor about the verification process.*