San Bernardino County
Department of Behavioral Health
Referral Summary for Referral to Managed Care Plan (MCP)

Beneficiary Name: _____
Beneficiary DOB: _____ **Age:** ___
Preferred language: _____
Assigned MCP: IEHP _____ **Health Net** _____ **Kaiser** _____ **Molina** _____

Clinical Information

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.	☐

Current Functioning

Area of Functioning	**Explanation** (Include brief description of strengths and needs)
Health/Self-care/Housing	
Occupation/Education	
Legal	
Money Management	
Interpersonal/Social	

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Discharge Diagnosis

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

Has beneficiary agreed to referral to Managed Care Plan?

Yes _____
No _____

Signature of Person Completing Referral Summary

_____

Printed Name of Person Completing Referral Summary

_____

Date Referral Summary Completed

_____

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**

☐ **No longer meets SMHS per Title 9. DBH/MHP will provide services while MCP transitions care.**