Optum TERM Mental Health Referral for Parent

See When to Refer for Group and/or Individual Therapy services- Parent flow chart.

A. PSW/PSS INFORMATION

CFWB Office/Program: <select> Date of Referral:

Name of SW:		Phone Number:		SW Email:	
PSS Name:		PSS Phone number:		PSS Email:	

Assigned/Covering PSS Signature: _____

Note To Provider: If you are unable to locate the SW with information provided above, call Hotline Records at (858) 514-6995 and provide code "BHS2021" to obtain SW information.

B. PARENT REFERRAL INFORMATION Enter parent's LEGAL name as it appears on their case record

Last Name:		First Name:		Alias	
DOB:		State ID:		Two Digit Person Number	
Gender:	<select>		Pronoun(s):	<select>	
Language:	<select>	Ethnicity:	<select>	If "Other" Ethnicity specify	
If service is to be provided in a language, include it here:					
Address:		Phone Number			
☐ Parent is unhoused		Zip code where the parent is most frequently located:			
Cultural Considerations (Include gender identity, sexual orientation, and any cultural or other considerations to support appropriate provider matching and address individual needs):					

C. FUNDING INFORMATION

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Mental health services will be provided in:	☐ San Diego County	☐ Other
Medi-Cal Number or CIN number:		Issue Date
☐ Parent indicated and SW confirmed they have private insurance/TRICARE/Other non-Medi-Cal insurance.		
Adults must call (866) 262-9881 to obtain their Medi-Cal and issue date **If referral is for Group treatment, Medi-Cal information is not necessary.**		

D. FAMILY INFORMATION

To avoid conflicts of interest, list legal names of the family members who will be receiving treatment through Optum TERM and children who are involved on the case plan.

Legal Name / Alias	Relationship to Child/Youth/NMD	DOB
1. /		
2. /		
3. /		
4. /		
5. /		
6. /		
7. /		
8. /		
9. /		
10. /		

E. REASON FOR REFERRAL AND FAMILY INFORMATION

Case Status:	<select>	Highly Vulnerable Child Case	<select> *For the purposes of provider assignment, Interns cannot be assigned if case is HVC.*	Court Ordered:	<Select>
Date of Next Court Hearing:					
Type of Therapy Requested (One therapy request per referral):					

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☐ Group Therapy (Select type of group): Select one

☐ Individual Therapy

☐ Conjoint between parents to facilitate child's therapeutic healing
If DV/IPV, conjoint treatment only AFTER successfully completing DV offender or DV victim group therapy

Safety/Risks Concerns (reasons CFWB opens a case):

☐ DV/ Intimate Partner Violence (IPV)	☐ Physical abuse
☐ Sexual Abuse	☐ Severe Neglect
☐ Emotional Abuse	☐ General Neglect and there are parental mental health concerns.

Describe the incident(s) that brought this family to CFWB's attention (impact on child):

Mental Health Symptoms (e.g., depression, anxiety, behavioral dysregulation, recent psychiatric hospitalizations, suicidal ideation, Serious Mental Illness symptoms etc.) ☐ N/A

Include any known diagnoses (e.g. mood disorder, Autism Spectrum Disorder Diagnosis): ☐ N/A

Additional information including complicating factors: (e.g. intellectual disability, SUD, challenges with daily activities) ☐ N/A

If known, please list other agencies/professionals providing services to the parent or family system: ☐ N/A

Current restraining order/history of threats to CFWB or others/other safety considerations: ☐ N/A

SERVICE DELIVERY METHOD

See CFWB TELEHEALTH CRITERIA for guidance

☐ Either telehealth or in-person are appropriate for this client and client meets CFWB Telehealth Criteria
☐ In-person only
☐ Telehealth only and the client meets CFWB Telehealth Criteria.

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F. SCHEDULE AND TRANSPORTATION CONSIDERATION
Optum will attempt to accommodate limitations but cannot guarantee scheduling preferences.

Transportation Limitations:		☐ N/A
Scheduling Limitations:		☐ N/A

G. REASSIGNMENTS OR SPECIFIC PROVIDER REQUEST (IF NOT APPLICABLE LEAVE BLANK)

Reassignment Request:

• Provider's name with active authorization	
• What is the reason for the reassignment?	
• Do you want Optum to end the previous provider's authorization?	

Name of specific TERM provider requested:	
If a specific provider requested, SW has confirmed with the provider that they are able to serve this parent: Select one	

ACTION REQUIRED BY SW: Submit the 04-176A to Office JELS Staff to submit to Optum TERM

Once assigned, send relevant documentation to the provider to support client treatment (e.g., JD report, status reviews, addendums, case plan, mental health history)