**MOU Care Coordination Request Form**

*Please submit request to the Healthcare Oversight Unit through* ***secure e-mail*** *at*

***BHSCaseConferences.HHSA@sdcounty.ca.gov***

Please consider the following prior to requesting a case conference:

* *Have all facilities given final declines without possible reconsideration?*
* *Has any necessary consultation with the Managed Care Plan, Public Conservator’s Office, Case Management Provider or other pertinent/relevant party occurred prior to this request?*
* *Please be prepared to provide historical information as well as present functioning, clinical picture, barriers to placement, completed referrals and attempted interventions during the case conference.*
* *Please note that case conferences do not impact placement waitlists or guarantee acceptance to desired placement.*
* *Please fully complete this form.*

**Please select which MOU this coordination is being requested for to ensure the appropriate party is available.**

#### [ ]  Child Welfare Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.1 Children’s Emergency Shelter Care Center (Polinsky Children’s Center)

#### [ ]  Behavioral Health Services\_\_\_\_\_\_\_\_\_\_\_\_

2.1 Mental Health Plan (MHP)

2.4 Drug Medi-Cal Organized Delivery System

#### [ ]  Aging and Independent Services \_\_\_\_\_\_\_\_\_\_\_\_

4.1 In Home Supportive Services (IHSS)

4.2 Multipurpose Senior Services Program (MSSP)

#### [ ]  Public Health Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.1 California Children’s Services (CCS)

1.2 Child Health and Disability Prevention (CHDP) Program

1.3 Community Epidemiology

1.4 Immunization Program

1.5 Hansen’s Disease (HD) Program

1.6 Sexually Transmitted Disease (STD) Control Program

1.7 Office of AIDS Coordination (OAC) Program

1.8 Maternal, Child, Adolescent Health (MCAH) Program

1.9 Tuberculosis (TB) Control Program

1.10 Refugee Health Assessment Program (RHAP)

1.11 Targeted Case Management (TCM)

#### [ ]  San Diego Regional Center\_\_\_\_\_\_\_\_\_

* 1. Care Coordination

#### [ ]  Blue Shield Promise\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### [ ]  Community Health Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### [ ]  Kaiser\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### [ ]  Molina Healthcare\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Enhanced Care Management
	2. Community Supports
	3. Non-Specialty Mental Health
	4. Long term Care
	5. California Children Services

#### Required Information

 **DATE:** Click here to enter a date.

**REQUESTING PARTY’S CONTACT INFORMATION**

Name : Click here to enter text. Organization : Click here to enter text.

Phone Number : Click here to enter text. E-mail Address : Click here to enter text.

Relationship to Referred Individual : Click here to enter text.

**CLIENT INFORMATION**

Name : Click here to enter text.

Current Location : Click here to enter text.

DOB : Click here to enter text.

CIN # : Click here to enter text.

☐Voluntary ☐Conservatorship

Income (*BHS-Specific*) : Choose an item. Insurance (*BHS-Specific*) : Choose an item.

MCP (*BHS-Specific*) : Choose an item.

Legal Status (*BHS-Specific*) : Choose an item.

MH Civil Court Involvement (*BHS-Specific*) : Choose an item.

Competency (*BHS-Specific*) : Choose an item. Justice Involvement (*BHS-Specific)*: Choose an item.

[ ]  Non-Conserved State Hospital Step-down Max Commitment Date: Click here to enter text.

 (*BHS-Specific*) (*BHS-Specific*)

**CLIENT CLINICAL PROFILE**

Mental Health Diagnosis: Click here to enter text.

Substance Use Diagnosis: Click here to enter text.

Medical Issues (BHS-Specific): Click here to enter text.

Previous Placement:Click here to enter text.

Referrals Made (*BHS-Specific*): Click here to enter text.

**Reason for Case Conference:** Choose an item.

If “*Other*”, please specify: Click here to enter text.

**Clinical Summary (see 3rd dot point at top of form) (*BHS-Specific*)?**

Click here to enter text.

**What is the Desired Outcome for this meeting (*BHS-Specific*)?**

Click here to enter text.

**Recommended Outcome:**

Click here to enter text.

**In addition to representatives from the BHS Healthcare Oversight Unit, Optum, and the Public Conservator’s Office who are regularly in attendance, are there other relevant service partners who should be invited, e.g., Case Manager, Health Plan Rep, SD Regional Center, PERT, COR etc.**

(*Phone numbers and email addresses are REQUIRED*):

1. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:* Click here to enter text.
2. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:* Click here to enter text.
3. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:* Click here to enter text.
4. Click here to enter text. *Tel. No.:* Click here to enter text. *Email:* Click here to enter text.

*You will be notified of the date, time, and location of the next case conference. Thank you.*

**FOR BHS USE ONLY (BHS-Specific):**

Review Summary (BHS-Specific): Click here to enter text.

Reason Case Conference was not scheduled (BHS-Specific): Click here to enter text.

Date/Time Case Conference was scheduled (BHS-Specific): Click here to enter text.

Outcome of Case Conference (BHS-Specific): Choose an item.

Action Items Discussed (BHS-Specific): Click here to enter text.

Additional Notes (BHS-Specific): Click here to enter text.