Request for TERM-Appointed Evaluator

SW INFORMATION

Date:

SW Name: Phone #: Fax #:

SW Email: Region/Centralized Program: <select> Program: <select>

PSS Name: PSS Phone # PSS Email:

PSS Signature:_________________________________ Date PSS signed: ________________

Protective Services Program Manager (PSPM) Name: PSPM Phone #

PSPM Signature: ______________________________ Date PSPM signed: ______________

CLIENT/CASE INFORMATION

Name of Client: Gender: <select> DOB: State ID: Two Digit Person #:

San Diego Medi-Cal?: ☐No ☐ Yes If yes, Medi-Cal# Medi-Cal Issue Date:

Language: <select> If client is a child/youth indicate language of their parent/caregiver:<select>
Ethnicity: <select> If "Other, please specify:

Client's/Caregiver's Name and Address (including facility name, if any):

Client's /Caregiver's Phone Number:

☐ Voluntary ☐ Pre-jurisdiction ☐Court-Ordered **Next Court Date:**

Optum makes every effort to assign a TERM psychologist who is a clinical match for the referred client. Please assist this process by providing the following information:

Safety Threats and Risk Factors (from SDM assessments):

Describe the incident that brought this family to CWS' attention (i.e. The safety concern that resulted in CWS involvement; the Harm Statement):
Date of the incident:
What is going on in the case right now (i.e. Case plan elements; Danger Statement and Safety Goals):
Why is this service being requested at this time (**INCLUDE** emotional, social, behavioral, developmental concerns for the child/adolescent **OR** specific mental health concerns about the parent):

CHECK ALL THAT APPLY:

☐ A CHILD IN THIS CASE IS UNDER 3 YEARS OF AGE: For parents with children under 3, the statutory time limit for reunification services is 6 months. However, services can be extended up to 6 additional months if the parent makes substantive progress in court-ordered treatment and services prior to the review hearing.

☐ Highly Vulnerable Child(ren) Case: A higher-than-average possibility exists of serious re-injury or death to a child. Case may include:

- severe physical abuse with serious non-accidental injuries to the head, face or torso in children age five years or younger, or children who are developmentally delayed at a functional level of five years or younger
- child's parent or guardian caused the death of another child through abuse or neglect
- infant born to parents currently involved with CWS or pas involvement with CWS and did not successfully reunify

Request for TERM-Appointed Evaluator

COMPLETE THIS SECTION FOR CHILD/ADOLESCENT REFERRAL

Requested Evaluation Due Date:

☐ Child at PCC, Juvenile Hall, or Adjunct bed **NOTE:** 10 day turnaround required for work product completion once authorization and case related records have been received by the provider.

☐ Parental rights have been legally terminated

REASON FOR REFERRAL (Check ONE):

☐ **An adoption is finalizing for a child and an evaluation of the child's social, emotional, behavioral, and cognitive functioning is required as part of the adoption finalization process.**

☐ **A petition has been or will be filed under Section 300(c) (Emotional Damage) and there is no therapist for the child who can evaluate and document emotional damage.**

☐ **Diagnostic Clarification and Treatment Recommendations are needed**: There are specific, **new** clinical reasons why the evaluation is being requested **at this particular time**. *(Please check the **ONE** box below that indicates the reason for the psychological evaluation):*

☐ Client's behavior and/or symptoms have recently and severely escalated **AND** the treating **licensed** mental health professional has documented in writing the following information: description of specific changes in behavior and/or symptoms and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.

OR

☐ Progress in therapy has been minimal **AND** the treating **licensed** mental health professional has documented in writing the following information: why progress has been minimal and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.

OR

☐ CWS is requesting a psychological evaluation for diagnostic clarification and treatment purposes because the child is not making expected progress in current interventions and has not appeared to benefit from treatment e.g. talk therapy, art therapy, play therapy, behavioral interventions.

OR

☐ CWS is requesting a psychological evaluation for diagnostic clarification and treatment purposes because the child is showing symptoms of significant mental illness (e.g. appears to exhibit psychotic symptoms) and there are no records from current/past mental health professionals available to guide treatment decisions.

Request for TERM-Appointed Evaluator

COMPLETE THIS SECTION FOR PARENT REFERRAL

Requested Evaluation Due Date:

Date by which parent must demonstrate substantial progress in services (6 or 12 Month Review date):

Has the parent threatened CWS staff or others (Restraining Orders? Propensity for violence?):

Client (check all that apply):

☐ Is the offender
☐ Is the non-protecting parent (NPP)
☐ Denies allegations/true finding
☐ Accepts responsibility/true finding

REASON FOR REFERRAL (Check ONE– Evaluations can only be completed to answer ONE of the following):

☐ **Diagnostic Clarification and Treatment Recommendations are needed**: There are specific, **new** clinical reasons why the evaluation is being requested **at this particular time**. *(Please check the **ONE** box below that indicates the reason for the psychological evaluation)*

☐ Parent's behavior and/or symptoms have recently and severely escalated **AND** the treating **licensed** mental health professional has documented in writing the following information: the specific changes in the parent's behavior and/or symptoms and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.

OR

☐ Progress in treatment has been minimal **AND** the treating **licensed** mental health professional has documented in writing the following information: why progress has been minimal as related to the mental health concerns of the client and why a psychological evaluation is necessary at this time to clarify diagnosis and appropriate interventions.

OR

☐ CWS is requesting a comprehensive psychological evaluation for diagnostic clarification and treatment purposes because the parent is not making expected progress, due to a documented mental health concern in demonstrating acts of protection and ability to parent safely.

OR

☐ CWS is requesting a comprehensive psychological evaluation for diagnostic clarification and treatment purposes because the parent is evidencing clear symptoms of significant mental illness and there are no records from current/past mental health professionals.

☐ **Does this parent have a mental disability, as defined in Family Code Section 7827** as a "mental incapacity or disorder that renders the parent unable to care for and control the child adequately"? A request for this evaluation will assess whether the parent is capable of utilizing reunification services and their prognosis for benefiting from the services to safely parent the child(ren) within reunification time frames.

ADOPTIONS PROGRAM ONLY- Psychological Evaluation of a Prospective Adoptive Parent:

☐ **Diagnostic Clarification and Treatment Recommendations are needed**: There are specific clinical reasons why the evaluation is being requested **at this particular time**. *(Please check the **ONE** box below that indicates the reason for the psychological evaluation)*

☐ The client denies significant mental illness but CWS suspects that mental illness is contributing to the risk factors, protective concerns, or placement issues. The client presents with concerning behaviors: odd, labile, reactive. There may be a history of mental illness and/or significant family dysfunction in client's family of origin, and/or the client failed to protect her/his biological children in the past. For these reasons, CWS has concerns about the client's mental health and consequent ability to emotionally connect with, and safely parent, the

adoptive child.

OR

☐ The client has a mental health diagnosis and may be on psychotropic medications, but is not functioning well. There may be additional medical conditions possibly impacting the client's functioning. There may be concerns that psychotropic or other prescribed medications are contributing to the client's poor functioning.

OR

☐ The client has significant criminal or drug history. Specific rule/out is requested for anti-social and/or narcissistic traits that, if present, could impact ability to safely parent.

****ACTION REQUIRED****

SW: *Submit 04-178 to Regional JELS Staff to send to OptumTERM. OptumTERM will forward to provider with the CWS authorization once provider is confirmed.*

Send case records to the provider once they have been confirmed *as per the Policy Manual:* *Mental Health Treatment*

Timelines for evaluators DO NOT begin until all case documents have been received.

FOR TERM PROGRAM USE ONLY

Date Received:	Processed by (OptumHealth Staff Name)	
Name of Provider Recommended:	Date Provider Accepted Referral:	
Provider's Address:	Provider's Phone:	
CWS SW Name:	Date and Mode of CWS Notification of Acceptance	Date: ☐ Telephone ☐ E-mail