# CALAIM JI BEHAVIORAL HEALTH ASSESSMENT AND LINKAGE REFERRAL

## CLIENT INFORMATION

***Instructions**: Please complete this section for the client being referred.*
***Refer to page 2 for the <u>required</u> documents that must be submitted with this form.***

**Projected Release Date (must be within 90-day):**

**REQUEST:** ☐ **Urgent: 48 hours of release** ☐ **Routine: 10 business days of release**

**Services Requested (Check all that apply):** ☐ **Mental Health** ☐ **Substance Use Disorder**

| | | | |
|---|---|---|---|
| **Interpreter Needed:** ☐ **Yes** ☐ **No** | | **Primary Language:** | |
| **Client/IP Name:** | **DOB:** | **SSN:** | **X-Ref:** |
| **Medi-Cal Client ID #:** | | **Has Active Medi-Cal?** ☐ **Yes** ☐ **No** | |

**JI Aid Codes** *(check all that apply)*: ☐ **12** ☐ **13** ☐ **14** ☐ **15** ☐ **16**

| | |
|---|---|
| **Referring Facility:** | **Facility County:** |
| **Facility Contact Name:** | **Facility Contact Phone:**<br>**Facility Contact Email:** |

**Relevant Mental Health information:**

**Source(s):**

| | |
|---|---|
| **Substance Use:** ☐ **Yes** ☐ **No** ☐ **UNKNOWN** | **Preferred drug(s):** |

**Substance Use History/Concerns:**

**Charges/Description & Other notes:**

**History of/Charge of/Conviction of:** ☐ **290** ☐ **Arson** ☐ **N/A**

**Victim related crime:** ☐ **Yes** ☐ **No**

**Special orders** *(check all that apply)*

☐ **Cannot reside with victim** ☐ **Peaceful contact order** ☐ **N/A**
☐ **Restraining order** ☐ **No contact order**

| | |
|---|---|
| **Client Contact Number on release:** | **Homeless:** ☐ **Yes** ☐ **No** |
| **Address upon release:** | **Income source/funding:** |

| SUBMITTER REVIEW<br>*Please review the information provided above is accurate and correct, sign and date.* | |
|---|---|
| **Reviewed By** *(PRINT)*: | **Date:** |
| *(SIGNATURE)*: | **Phone:** |

**Please confirm you have attached the following <u>required</u> documents:**

- ☐ **MCP/MHP Screening Tool**
- ☐ **LIST (only for FSP-level services)**
- ☐ **BQuIP (only for SUPT services)**
- ☐ **ROI**
- ☐ **Documentation of Verbal Consent**
- ☐ **Other:**
- ☐ **Other:**

***Submit the full packet to:*** ***dhs-bhs-jailreferral@saccounty.gov***

| DEPARTMENT OF HEALTH SERVICES, BEHAVIORAL HEALTH SERVICES | | |
|---|---|---|
| **ROI Date:** | **Date of assignment:** | **Completion date:** |
| **Mental Health Diagnosis:** | | **Primary** ☐ **Yes** ☐ **No** |
| **Substance Use Diagnosis:** | | **Primary** ☐ **Yes** ☐ **No** |

**Level of Care Recommendation:**

☐ **MCP** ☐ **CORE/OP** ☐ **FSP** ☐ **Not Eligible for MHP** ☐ **Other** *(see notes)*

**SUPT Treatment Recommended:**

- ☐ **No**
- ☐ **Yes** *(specify)*:

**Recommendation Notes:**

| **Assigned SMHC** *(PRINT/SIGN)*: | **Date:** |
|---|---|