ADULT MENTAL HEALTH
INTENSIVE SERVICES REQUEST*

**For individuals identified as ready for step-down from subacute placement*

Client Name:	**DOB:**	**Gender:** ☐ M ☐ F ☐ Non-binary ☐ Other:

Avatar ID:	**SSN:**	**Client's Preferred Language:**

Referral Source:

Name: Title:

Contact Information: Date:

☐ In agreement with step-down to high-intensity, community mental health services

Legal:

☐ LPS Conservator ☐ Probate Conservator ☐ Probation ☐ Registered Sex Offender

Describe prominent symptoms/behaviors reported by the client and/or treatment team and any high risk factors:

Co-morbid health or medical conditions reported:

☐ Has a Primary Care Physician

Name/Medical Group:

Contact Information: Date of last appointment:

Personal Supports (e.g., family, friends, peer groups, AA, NA, church):

Client Strengths:

Insurance: ☐ **Medi-Cal** ☐ **Medicare** ☐ **Other:**	**Funding:** ☐ **SSI** ☐ **SSDI** ☐ **SSA** ☐**Private:**	**Payee Service:**

Current Housing: ☐ **Yes** **Type:**

☐ **No** **Type of Housing Requested (check all that apply):** ☐ B&C ☐ R&B ☐ Family ☐ **Other:**

Current Subacute Service Provider:

Contact Name: Contact Number:

ADULT MENTAL HEALTH
INTENSIVE SERVICES REQUEST*

CONFIDENTIAL CLIENT INFORMATION ***See W&I Code 5328***	**Client Name:**
	Avatar ID:

Diagnosis provided by treatment team: (Include co-occurring substance use disorders if applicable, in order of prevalence starting with primary Dx.):

- Primary Dx:
- Additional Dx:

Recommended current target behaviors for Service Plan:

Please attach the following documents if available:

☐ Most recent medication list from the current treatment team

☐ Wellness & Recovery Plan/Crisis Plan

☐ Living Skills/Functional Assessment

☐ Behavioral or Service Plan

☐ HRL

☐ Medication List

☐ **Date of next injection (if applicable):** **Date of blood draw (if applicable):**

☐ **Please see injectable med list (if applicable)**

Please fax to the Sacramento Intensive Placement Team: (916) 854-8824

Intensive Placement Team only:

Date referral received: _____

Date of authorization: _____