



# **Level of Intensity**

## **Screening Tool (LIST)**

**Sacramento County Department of Health Services**

**Division of Behavioral Health services**

**Last Update- January 2025**

### Level of Intensity Referral Form

Please complete the screening tool and fax or e-fax it to IPT at (916) 854-8824 or [DHS-Fax-MH-IPT@SacCounty.gov](mailto:DHS-Fax-MH-IPT@SacCounty.gov).

Date of Referral:	
Client Name (Birth):	Date of Birth:
Preferred Name:	Gender Identification :
Client ID/Medi-Cal# (CIN):	Pronouns:
Ethnicity:	Client's Preferred Language: Interpreter preferred? Yes
Conservator? Yes No	Type: LPS Probate Conservator Name:
Conservator Email:	Phone Number:
Current Location: Hospital (Psychiatric) – Reason for admit: DTS DTO GD In community/Home <input type="checkbox"/> Jail -Anticipated Release Date: <input type="checkbox"/> Other (please list) <input type="checkbox"/> Unhoused/ Encampment: specify the area	
<b>Is the client in agreement with receiving services: YES</b>	
Collateral Documents Attached:	Assessment Medication List Progress notes Other:
Co-occurring substance use (If applicable, please list): Tested Positive at Admission (for Inpatient use)? Yes No	
Current Housing: Independent Living Family Room and Board Board and Care <input type="checkbox"/> Temporary Housing Unhoused <b>(Please complete the attached Homeless Checklist).</b>	Can return to that residence? Yes No
Insurance: Medi-Cal Medicare Uninsured Other:	Funding/ Income:
Support system: Family Peers Volunteer/Employment Spiritual/Religious NA/AA Other:	
Primary Diagnosis and Presenting Symptoms:	
<b>Referring Agency</b>	
Submitting Program/Agency:	Email:
Contact Person:	Phone Number:
Level of Care Requesting:	High Intensity Outpatient Services Secure Setting
<b>Current Outpatient Provider</b>	
Outpatient Provider name:	Contact person:
Contact person phone number:	Contact person email:
Date Contacted:	Current provider is in agreement with transferring to a high intensity service
Supervisor's Name:	Supervisor's email:

**Instructions: In each domain, mark all that criteria that apply. Only one intensity score will be given per criteria section**

Domain	Severe (3)	Moderate (2)	Mild (1)	N/A	Score
<p><b><u>Clinical Complexity</u></b></p> <p>Serious and persistent mental illness vs. situational or reactive, recovery status, functional impairment, treatment engagement, psychiatric hospitalizations</p>	<input type="checkbox"/> Psychiatric hospitalizations: 1+ within past 6 months or current sub-acute placement	<input type="checkbox"/> Psychiatric hospitalizations: 1+ within past year	Psychiatric hospitalizations: None within past year		
	Past exposure to & use of treatment: 2 or more outpatient services per week for multiple months	Past exposure to & use of treatment: less than 2 outpatient services per week	Past exposure to & use of treatment: no previous MH treatment history		
	Level of engagement: minimal engagement with mental health treatment (inpatient and/or outpatient)	Level of engagement: limited engagement with mental health treatment providers (inpatient and/or outpatient)	Level of engagement: fully engaged		
<p><b><u>Risk Factors</u></b></p> <p>Suicidal/homicidal behavior, gravely disabled, violent, high risk behavior, impulsivity</p>	Suicidal / Homicidal Ideation: Recent or current <u>active ideation with intent and plan</u> within the past month	Suicidal / homicidal ideation: active ideation <u>without</u> intent to follow through within the past month	Suicidal / homicidal ideation: passive ideation within the past month		
	Danger to self or others: attempts within the past month	Danger to self or others: attempts within the past 12 months	Danger to self or others: History of attempts or threats		
	Evidence of self-neglect: current compromise of ability to care adequately for oneself, despite prompting, and at detriment to health and safety	Some evidence of self-neglect: decreased ability to care for oneself but responds well to structure and prompts	Periods of self-neglect in the past without current evidence of such behavior.		
	Recurrent incarcerations in the last 12 months or released within 90 days	History criminal justice involvement or released within a year from a jail or prison	Remote history of criminal justice involvement		
	High risk behaviors/ impulsivity that increases the risk of disease, injury, disability, or death within last month. It may include interactions with crisis system partners.	High risk behavior/ impulsivity that increases the risk of disease, injury, disability, or death within last 6 months. It may include interactions with crisis system partners	Remote history of high risk behavior/ impulsivity that increases the risk of disease, injury, disability or death		

\*Describe all risk factors checked (needs to be filled):

Domain	Severe (3)	Moderate (2)	Mild (1)	N/A	Score
<p><b><u>Life Circumstances</u></b></p> <p>Ability to fulfill social responsibilities, availability of resources, environmental stressors, family/social/faith-based support</p>	Chronic homelessness: experiencing literal homelessness for at least 12 months consecutively OR occasions of homelessness (add up to at least 12 months over the last 3 years)	Literal homelessness: sleeping in a place not meant for human habitation or an emergency shelter	Imminent risk of homelessness: will likely lose housing in the next 14 days without intervention or change in circumstances		
	Relationships / support: no resources & support, or only relies on behavioral health system for resources & support	Relationships / supports: limited resources & support	Relationships / supports: adequate resources & support		
	Requires extensive level of support with case management needs such as housing, Job, School, Transportation, Accessing resources, ADLs, Financial Management, physical health, caregiver responsibilities or support with medication management	Requires moderate level of support with case management needs such as housing, Job, School, Transportation, Accessing resources, ADLs, Financial Management, physical health, caregiver responsibilities or support with medication management	Requires low level of support with case management needs such as housing, Job, School, Transportation, Accessing resources, ADLs, Financial Management, physical health, caregiver responsibilities or support with medication management		
<p><b><u>Co-morbidity</u></b></p> <p>Medical or Substance Use</p>	Extensive medical conditions exist that have an impact on or are impacted by client MH symptoms and require ongoing monitoring	Medical conditions exist or have the potential to develop. These conditions would impact or are impacted by client MH symptoms and do not require extensive monitoring	Medical conditions exists but are not immediately threatening or debilitating and have no impact on the course of presenting mental health condition		
	Uncontrolled substance use occurs at a level which poses a serious threat to health if unchanged and /or poses a serious barrier to recovery from any co-existing psychiatric disorder	Recent or ongoing substance use occurring despite negative consequences with significant or potentially significant impact on the course of any co-existing psychiatric disorder	Occasional episodes of substance misuse but any recent episodes are self-limited, show no pattern of escalation and there is no indication that they adversely affect the course of a co-existing psychiatric disorder		
Describe items checked / Additional information (needs to be filled):					<b>Total Score</b>
The assigned provider will conduct a comprehensive housing needs assessment to determine most appropriate housing services and supports					
<b>For County Use Only- Approved Level of Care</b>					
32 to 39	Consider Sub-acute Referral	22 to 31	Full Service Partnership		
13 to 21	CORE or Court/Justice involved Outpatient programs	0 to 12	Managed care / PCP		

**Please complete applicable sections for specialty Full Service Partnership (FSP) programs**

Program	Program Description	Specialty Eligibility
<p><b>EI Hogar, CJSP</b> (Community Justice Support Program)</p>	<p>The Community Justice Support Program is a FSP using a Multi System Team (MST) model to promote interagency and community collaboration to mental health services to Justice Involved individuals experiencing Serious Mental Illness.</p>	<p>Client is in agreement to participate in Multi-System Team (MST) Meetings</p> <p>MST Release- needs to be completed and signed by the client</p> <p>Involved in the criminal justice system (probation, parole, or mental health court)</p> <p>If Applicable, Probation/Parole Officer Name and Phone Number:</p> <p>Special Considerations (Ex: ambulatory needs, upcoming court appearances, Etc.):</p>
<p><b>EI Hogar, SEWP</b> (Sierra Elder Wellness Program)</p>	<p>SEWP provides specialized FSP level services for the growing older adult (age 55+)</p>	<p><input type="checkbox"/> 55 Years of Age and Older</p>
<p><b>APCC- TWC</b> (Transcultural Wellness Center at Asian Pacific Community Counseling)</p>	<p>APCC TWC provides services to the clients in all ages who require culturally sensitive services and supports in order to engage in services and recovery.</p>	<p>Requesting culturally sensitive services due to linguistic or community acculturation needs</p>
<p><b>TAY FSP</b> Transition Aged Youth (TAY) FSP at Capital Star's Community Services</p>	<p>Capital Star Community Services serves young adults ages 16-25 through a FSP program that provides mental health services and supports young people's independence.</p>	<p>Between the ages of 16 and 25</p> <p>Youth is agreement and identifies need for TAY FSP services including frequency of services</p> <p><b><u>At least 2 transition to adulthood identified:</u></b></p> <p>Profound impairment in ability to live independently</p> <p>Challenges with meeting parenting responsibilities that are placing the youth's child at risk for out of home placement</p> <p>Frequent difficulty navigating transportation that creates barriers to improvement through mental health treatment</p> <p>Unable to manage significant health conditions independently</p> <p>Loss or risk of loss of educational placement or vocational due to emotional and behavioral disturbance</p> <p>Difficulty following through with obtaining financial assistance, financial hardship, or poverty that has a destabilizing effect</p>
<p><b>THRIVE FSP</b> (Transformative, Healing, Renewing, Inclusive, Voice, Empowerment) FSP at Bay Area Community Services (BACS)</p>	<p>THRIVE FSP is a specialized justice involved outpatient mental health program designed for adults age 18 years and older.</p>	<p>Involved in the criminal justice system (probation, parole, or mental health court)</p> <p>If Applicable, Probation/Parole Officer Name and Phone Number:</p> <p>Recent release from jail or prison (<b>within the last 6 months</b>)</p>

# Homelessness Checklist

**1. Is the individual sleeping in a place not meant for human habitation or an emergency shelter? If yes, select one of options below. For the individuals currently hospitalized or incarcerated, where was the person prior to entering the hospital or jail?**

Car, van or camper not hooked up to facilities.

Outdoors/encampment

Homeless shelter Specify name(s):

Hotel/motel paid for by non-profit/county funding

Other location not meant for humans to live (e.g. storage shed)

None of the above (Individual does not meet the definition of chronic or literal homelessness)

**2. How long has individual been experiencing homeless?**

Individual has been continuously sleeping in the place checked above or a combination of places listed above for at least 12 months

Individual has been intermittently experiencing homelessness (in a place or combination of places listed above) and housed. The occasions of homelessness (add up to at least 12 months over the last 3 years

The individual is newly experiencing homelessness (less than 1 year)

**3. If the individual is current hospitalized or incarcerated:**

Individual has been in the hospital or jail for less than 90 days (up to 89 days)

Individual has been in the hospital or jail for 90 days or longer (Individual does not meet the definition of chronic or literal homelessness)

**4. Evidence of homelessness can be provided, in order of priority. Check all that apply**

Documentation from third party (e.g., neighbor, private citizens, police/sheriff, CPS/APS, conservator, shelters, store owners

Documentation from case managers such as notes, discharge paperwork or a letter on letterhead that state the beginning and end dates

Self-Certification by the individual of up to 25% of the homelessness time. E.g., 3 months out of the 12 months of homelessness can be self-certification



County of Sacramento  
**Authorization To Release  
 Information To Multi-System  
 Team (MST)**

NAME/ADDRESS/PHONE OF COUNTY PROGRAM:

<b>Client Name (First, Middle, Last): *Print Neatly*</b>	
<b>Date of Birth:</b>	<b>Record #:</b>
<b>Address:</b>	
<b>City/State/Zip Code:</b>	
<b>Phone #: (        )</b>	
<b>Other contact info:</b>	

**NOTE: Records relating to mental health, or substance use disorder, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:**

- |   |                   |
|---|-------------------|
| <input type="checkbox"/> Mental Health records          | <b>Signature:</b> |
| <input type="checkbox"/> Substance Use Disorder records | <b>Signature:</b> |
| <input type="checkbox"/> HIV antibody test results      | <b>Signature:</b> |

**INFORMATION TO BE RELEASED** (Clearly describe the information that may be disclosed.)

**Check all that apply**

- |   |   |
|---|---|
| <input type="checkbox"/> All Medical Records ( <u>Except Mental Health, Substance Use Disorder or HIV unless indicated in section above</u> ) |   |
| <input type="checkbox"/> Lab Tests  | <input type="checkbox"/> Attendance Only Records                              |
| <input type="checkbox"/> Medication   | <input type="checkbox"/> Consultation Reports/Physician Order                 |
| <input type="checkbox"/> Treatment/Personal Service Plan  | <input type="checkbox"/> Progress Reports/Notes                               |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Psychiatric/Psychological Assessment/Testing Results |
| <input type="checkbox"/> Social History   | <input type="checkbox"/> Billing or Payment Information                       |
| <input type="checkbox"/> Records from a specific visit or hospitalization (Enter date and location): _____                                    |   |
| <input type="checkbox"/> Other ( <b>Must describe—add sufficient detail</b> ): _____  |   |

**PURPOSE:** The information disclosed to the MST may only be used for the following purpose(s):

**I understand that my confidential information indicated above will be discussed or disclosed to the following MST team members (check only those that apply):**

**Team Members (list by name or class/role or entity):**

<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____

**EXPIRATION:** This Authorization will expire on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ date. (mm/dd/yyyy) (Must be no more than one year from the date of signature.)

- **REVOCATION:** You or your personal representative can revoke this authorization at any time upon written request. Revocation will take effect upon receipt, except to the extent that others have acted upon this authorization prior to receipt of the revocation.
- **REDISCLASURE:** Re-disclosure of these records is not allowed unless another authorization is obtained from you, or such disclosure is specifically required or permitted by federal or state law.
- **You have the right to receive a signed copy of this authorization.**

		/ /
<b>Client's Signature</b>	<b>Printed Name</b>	<b>Date</b>
		/ /
<b>Personal Representative's Signature</b>	<b>Printed Name</b>	<b>Date</b>

**STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE** (Print First & Last Name):

**Page 2 of 2: Give to Client with copy of Page 1**

**VERIFICATION:** We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

**VERIFICATION for Personal Representative:** If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the patient must provide documentation in writing appointing this person as a representative and this documentation must be attached.

**General Medical Records:** Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

**HIV, Substance Use Disorder, and Mental Health Treatment:** These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

Information in Substance Use Disorder records is protected by federal confidentiality rules (*42 CFR Part 2*). The federal rules prohibit redisclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided by law.

This authorization is voluntary. The client's health information may be protected under federal or state confidentiality laws. These federal or state laws may not apply to the person or organization receiving the information being shared. The client may choose not to sign this authorization and this will not affect their ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if client is eligible to enroll in the Sacramento County Health program, the client may not be able to show they qualify for these services.

**(If applicable)** Client understands that County of Sacramento has been asked to provide a health care service (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if client chooses not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to the client.

**VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:**

The authorization is missing the elements described below:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s) or class of person(s) or entity to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- A specific expiration date not to exceed one year from the client's signature.
- Signature of the client or client's personal representative and date.



**INSTRUCTIONS**  
**for the Multi-System Team Authorization Form 2099c**

**If a client is NOT part of a designated MST, use the HIPAA Form 2099 Authorization form.**

**VERIFICATION:** We are required to verify and confirm the client's identity with picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). Attach a copy of the picture identification.

**VERIFICATION for Personal Representative:** If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

**TEAM MEMBERS:** Must identify the team member(s)'s name or class/role and entity. For example, Sacramento County Probation Officer (not Probation Department), Sacramento County CPS Worker (not Child Protective Services), etc. If a new member class/role or name needs to be added, a new authorization must be obtained.

**ABOUT THE FORM:** This authorization is a **Voluntary Form**. Be sure the individual understands it before signing.

**EXPIRATION DATE:** The expiration date cannot exceed one year from the client's signature date. In addition, if this release is for an event, please enter the event expiration date.

**RIGHT TO REVOKE:** The individual has a right to revoke this form. When an individual revokes written authorization to disclose information, the County of Sacramento must boldly mark the authorization form "revoked" and include the date and signature of the requesting individual.

**COPY TO THE INDIVIDUAL: We must provide the individual with a copy of the signed authorization.**

**VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:**

1. The expiration date has passed or the one-time event is known by the covered entity to have occurred.
2. The authorization has not been filled out completely, with respect to any applicable elements described below:
  - A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
  - The name or other specific identification of the person authorized to make the requested use or disclosure.
  - A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
  - An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
  - Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.



**County of Sacramento  
AUTHORIZATION TO OBTAIN  
OR RELEASE PROTECTED  
HEALTH INFORMATION (PHI)**

**CONTACT:**

**Client Name (First, Middle, Last): \*Print Neatly\***

**Date of Birth:**

**Record #:**

**Address:**

**City/State/Zip Code:**

**Phone #: ( )**

**Email** (Optional-For Contact only)

**OBTAIN from** (Individual or Entity that has the Protected Health Information):

**RELEASE (disclose)** your Protected Health Information to:

**Recipient Name:**

**Address:**

**City/State/Zip Code:**

**Phone #: ( )**

**Fax #: ( )**

**PURPOSE:** The health information disclosed may only be used for the following purpose(s):

**INFORMATION TO BE RELEASED:**

All Medical Records (Except Mental Health, Alcohol/Drug or HIV unless indicated in next section)

Lab Tests

Attendance Only Records

Medication

Consultation Reports/Physician Order

Treatment/Personal Service Plan

Progress Reports/Notes

Discharge Summary

Psychiatric/Psychological Assessment/Testing Results

Social History

Billing or Payment Information

Records from a specific visit or hospitalization (Enter date and location):

Other (Must describe):

**NOTE: Records relating to mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:**

Mental Health records

**Signature:**

Alcohol/Drug dependency treatment records

**Signature:**

HIV antibody test results

**Signature:**

**EXPIRATION: This Authorization will expire on** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **date.** (mm/dd/yyyy) (Must be no more than one year from the date of signature.)

**REVOCATION:** You or your personal representative can revoke this authorization at any time upon written request. Revocation will take effect upon receipt, except to the extent that others have acted upon this authorization prior to receipt of the revocation.

**REDISCLASURE:** Re-disclosure of these records is not allowed unless another authorization is obtained from you, or such disclosure is specifically required or permitted by federal or state law.

**I understand that I have a right to a signed copy of this authorization.**

**Client's Signature**

**Printed Name**

**Date**

/ /

/ /

**Personal Representative's Signature**

**Printed Name**

**Date**

**STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE (Print Name):**

**VERIFICATION:** We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

**VERIFICATION for Personal Representative:** If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the patient must provide documentation in writing appointing this person as a representative and this documentation must be attached.

**General Medical Records:** Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

**HIV, Alcohol and Drug, and Mental Health Treatment:** These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

This authorization is voluntary. The client's health information may be protected under federal or state confidentiality laws. These federal or state laws may not apply to the person or organization receiving the information being shared. The client may choose not to sign this authorization and this will not affect their ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if client is eligible to enroll in the Sacramento County Health program, the client may not be able to show they qualify for these services.

**(If applicable)** Client understands that County of Sacramento has been asked to provide a health care service (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if client chooses not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to the client.

**VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:**

The authorization is missing the elements described below:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s) or class of person(s) or entity to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- A specific expiration date not to exceed one year from the client's signature.
- Signature of the client or client's personal representative and date.