Level of Intensity

Screening Tool (LIST)

Sacramento County Department of Health Services

Division of Behavioral Health services

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.net.

Client Information

Client Name (Birth): Date of Birth:

Preferred Name: Gender Identification :

Avatar ID/Medi-Cal# (CIN): Pronouns:

Ethnicity: Client's Preferred Language: Interpreter preferred? ☐ Yes

Conservator? ☐ Yes ☐ No | Type: ☐ LPS ☐ Probate | AOT Referred? ☐ Yes ☐ No

Conservator Name: Phone Number:

Current Location: ☐ Hospital (Psychiatric) – Reason for admit: ☐ DTS ☐ DTO ☐ GD ☐ In community/Home

☐ Jail -Anticipated Release Date: ☐ Other (please list)

☐ **Client in agreement to receive high intensity services**

Primary Diagnosis and Presenting Symptoms:

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
☐ Temporary Housing ☐ Unhoused **(Please complete the attached Homeless Checklist).**
Can return to that residence? ☐ Yes ☐ No

Insurance: ☐ Medi-Cal ☐ Medicare ☐ Uninsured ☐ Other:
Funding/ Income _____

Support system: ☐ Peers ☐ Family ☐ Volunteer/Employment ☐ Spiritual/Religious ☐ NA/AA ☐ Other:

Referring Agency

Submitting Program/Agency:

Contact Person: Phone Number:

Level of Care Requesting: ☐ High Intensity Outpatient Services ☐ Secured Setting

Current Outpatient Provider

Provider Agency: Provider Program:

Contact Person: ☐ Current provider is in agreement with transferring to a high intensity service provider

Phone Number: Date Contacted:

Supervisor's Name/Email:

For Kaiser Members Only:

Kaiser Contact Approving: Phone Number:

Kaiser OP Contact: Phone Number:

County Services Requested/Intensive Community-Based: ☐ Rehabilitation ☐ Case Management
☐ Psychiatric Medication Services ☐ Other _____

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
Clinical Complexity Serious and persistent mental illness vs. situational or reactive, recovery status, functional impairment, treatment engagement, medication complexity, psychiatric hospitalizations	☐ Psychiatric Hospitalizations: 1+ within past 6 months or sub-acute admission	☐ Psychiatric Hospitalizations: 1+ within past year.	☐ Psychiatric Hospitalizations: None within past year.	☐	0
	☐ Psychotropic Medication Stability: Not yet stable, stable for less than 6 months.	☐ Psychotropic Medication Stability: Stable for 6 to 12 months.	☐ Psychotropic Medication Stability: Stable for over a year.	☐	0
	☐ Past exposure to & use of treatment: history of high or moderate intensity services from an outpatient program	☐ Past exposure to & use of treatment: history of low intensity services from an outpatient program	☐ Past exposure to & use of treatment: no previous MH treatment history	☐	0
	☐ Level of Engagement: minimum engagement	☐ Level of Engagement: limited engagement	☐ Level of Engagement: fully engaged	☐	0
Risk Factors Suicidal/homicidal behavior, gravely disabled, violent, high risk behavior, impulsivity	☐ Suicidal / Homicidal Ideation: Recent or current active ideation, intent, or plan within the past 1 month.	☐ Suicidal / Homicidal Ideation: Active without intent to follow through within the past 1 month.	☐ Suicidal / Homicidal Ideation: Passive within the past 1 month.	☐	0
	☐ Danger to Self or Others: Recent or current attempts or threats within the past 1 month.	☐ Danger to Self or Others: No threats or attempts within the past 12 month.	☐ Danger to Self or Others: History of attempts or threats	☐	0
	☐ Clear compromise of ability to care adequately for oneself, despite prompting	☐ Some evidence of self-neglect or/and decrease the 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.	☐	0
	☐ 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	☐	0
	☐ Current or recent high risk behaviors/ impulsivity	☐ Recent History of high risk behavior/ impulsivity within last 6 months	☐ Remote history of high risk behavior/ impulsivity	☐	0

*Describe all risk factors checked:

Domain	Severe (3)	Moderate (2)	Mild (1)	N/A	Score
Life Circumstances Ability to fulfill social responsibilities, availability of resources, environmental stressors, family/ social/faith-based support	☐ Emotional Distress: Persistent as a manifestation of chronic symptoms related to mental health.	☐ Emotional Distress: Recurrent as a manifestation of symptoms of mental health, which are worsened by life stressors.	☐ Emotional Distress: Periodic as a manifestation of symptoms of mental health, which are worsened by life stressors.	☐	0
	☐ Relationships /Supports: No resources & support, or relies on behavioral health system for resources & support.	☐ Relationships / Supports: Limited resources & support	☐ Relationships/ Supports: Adequate resources & support	☐	0
	☐ Requires extensive level of support with case management needs such as housing, Job, School, Transportation, Accessing resources, ADLs, Financial Management, physical health, caregiver responsibilities	☐ Requires moderate level of support with case management needs such as: housing, Job, School, Transportation, Accessing resources, ADLs, Financial Management, physical health, caregiver responsibilities	☐ Requires low level of support with case management needs such as: housing, Job, School, Transportation, Accessing resources, ADLs, Financial Management, physical health, caregiver responsibilities	☐	0
Co-morbidity Medical or Substance Use	☐ Extensive medical conditions exists that impacts client MH symptoms and requires on going monitoring such as uncontrolled diabetes, cancer, heart conditions, neurological illnesses	☐ Medical conditions exists or have potential to develop but does not require on going monitoring such as diabetes, uncontrolled hypertension, mild pneumonia	☐ Medical conditions exists but are not immediately threatening or debilitating and have no impact on the course of presenting mental health condition	☐	0
	☐ 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	☐	0

Additional information/ Level of Care Recommendation:

Total Score 0

The assigned provider will conduct a comprehensive housing needs assessment to determine most appropriate housing services and supports

For County Use Only- Approved Level of Care

35 to 42	○ Consider Sub-Acute Referral	25 to 34	○ Full Service Partnership
16 to 24	○ CORE Programs	0 to 15	○ Managed Care / PCP

Please complete applicable sections for specialty Full Service Partnership (FSP) programs		
Program	**Program Description**	**Specialty Eligibility**
El Hogar, CJSP (Community Justice Support Program)	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.	☐ Client is in agreement to participate in Multi-System Team (MST) Meetings ☐ MST Release- needs to be completed and signed by the client ☐ Involved in the criminal justice system (probation, parole, or mental health court) If Applicable, Probation/Parole Officer Name and Phone Number: ☐ Special Considerations (Ex: Ambulatory Needs, Upcoming Court Appearances, Etc.):
El Hogar, SEWP (Sierra Elder Wellness Program)	SEWP provides specialized FSP level services for the growing older adult (age 55+)	☐ 55 Years of Age and Older
APCC- TWC (Transcultural Wellness Center at Asian Pacific Community Counseling)	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.	☐ Requesting culturally sensitive services due to linguistic or community acculturation needs
TAY FSP Transition Aged Youth (TAY) FSP at Capital Star's Community Services	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.	☐ Between the ages of 16 and 25 ☐ Youth is agreement and identifies need for TAY FSP services including frequency of services **<u>At least 2 transition to adulthood identified:</u>** ☐ Profound impairment in ability to live independently ☐ Challenges with meeting parenting responsibilities that are placing the youth's child at risk for out of home placement ☐ Frequent difficulty navigating transportation that creates barriers to improvement through mental health treatment ☐ Unable to manage significant health conditions independently ☐ Loss or risk of loss of educational placement or vocational due to emotional and behavioral disturbance ☐ Difficulty following through with obtaining financial assistance, financial hardship, or poverty that has a destabilizing effect
Family FSP HeartLand Family Wellness Center	HeartLand Family Wellness Center serves youth (0-21) <u>and</u> their caregivers through a FSP program that provides mental health services to either the adult and/or the youth in the family	☐ Caregiver and/or youth in agreement and identify a need for Family FSP services including frequency of services ☐ Caregiver and/or youth in imminent threat of homelessness and/or experiencing vulnerabilities and risks associated with poverty that have a destabilizing effect and/or experiencing difficulty following through with obtaining financial assistance ☐ The family experiences intergenerational trauma that may include high ACES scores, factors found in the school to prison pipeline, eating disorders and/or court-ordered mental health treatment. ☐ The youth is at risk for loss of educational placement or the caregiver is at risk for loss of vocational placement due to emotional and behavioral conditions with either the youth or caregiver.

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:

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

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

☐ Mental Health records	**Signature**:
☐ Substance Use Disorder records	**Signature**:
☐ HIV antibody test results	**Signature**:

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

<u>Check all that apply</u>

☐ All Medical Records *(<u>Except</u> Mental Health, Substance Use Disorder or HIV <u>unless indicated in section above</u>)*

☐ 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 (**<u>Must describe--add sufficient detail)</u>**):

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 (<u>check only those that apply</u>):

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

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

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.
- **REDISCLOSURE:** Re-disclosure of these records is not allowed unless another authorization is obtained from you, <u>or</u> such disclosure is specifically required or permitted by federal or state law.
- **You have the right to receive 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 First & Last 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, 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.

REDISCLOSURE: 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.