

Referral for Qualified Individual Assessment

Child/Nonminor's Name:	
Date of Birth:	
Case Type:	
Medi-Cal Client ID Number (CIN):	Court ID#:

Do NOT submit Referral without signed Release of Information & Consent to Treat forms

Section A. Date and Reason for Referral

Date Referral Submitted:

Referral Submitted Prior to Placement in STRTP? Yes No

If no, date child was placed in STRTP:

QI Assessment Report Due Date: *See Instructions*

Reason for Referral:

- CFT Recommends STRTP Level of Care
- 14 Day Notice of Placement Change:
- Discharge from Hospitalization
- Court Order for Foster Care and/or Probation Recommends STRTP Level of Care
- Emergency Removal from Prior Placement
- Other

Provide summary of rationale for QI Referral:

Note: a lack of available family homes is not an acceptable rationale for placing a child in an STRTP:

All Sections must be complete

Section B. Contact Information –

Referring Agency, Worker Name:		<input type="checkbox"/> CWS	<input type="checkbox"/> Juvenile Probation
		<input type="checkbox"/> *Dual Status Lead Agency:	
Contact Number:		Email:	
Office Address:			
Supervisor:	Contact Number:	Email:	
*Worker Name (dual status case):	Contact Number:	Email:	
Current MH Provider:		Email:	
Title:		Contact Number:	
		Secure Fax Number:	
Current SUD Provider:		Email:	
Title:		Contact Number:	
		Secure Fax Number:	
<input type="checkbox"/> Indian Child	Tribal Affiliation:		
	Tribal Representative:		
	Contact Number:		
	Email:		
<input type="checkbox"/> Regional Center Client	Regional Center Caseworker:		
	Contact Number:		
	Email:		
<input type="checkbox"/> Educational Rights Holder:	Name:		
	Contact Number:		
	Email:		

Complete all placement information in full

Section C. Current Caregiver Information

Current Placement Type:	Date of Placement:
Current Caregiver Name:	FFA or Placement Name:
Street Address:	City, State, Zip Code:
Telephone:	Email:

Section D. Members of the Child and Family Team

Name		
Relationship to youth:	Phone #: <input type="checkbox"/> Preferred Contact Method	Email: <input type="checkbox"/> Preferred Contact Method
Name		
Relationship to youth:	Phone #: <input type="checkbox"/> Preferred Contact Method	Email: <input type="checkbox"/> Preferred Contact Method
Name		
Relationship to youth:	Phone #: <input type="checkbox"/> Preferred Contact Method	Email: <input type="checkbox"/> Preferred Contact Method
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Relationship to youth:	Phone #: <input type="checkbox"/> Preferred Contact Method	Email: <input type="checkbox"/> Preferred Contact Method
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Relationship to youth:	Phone #: <input type="checkbox"/> Preferred Contact Method	Email: <input type="checkbox"/> Preferred Contact Method
Name		
Relationship to youth:	Phone #: <input type="checkbox"/> Preferred Contact Method	Email: <input type="checkbox"/> Preferred Contact Method

Section E. Health Information & Behavioral Health Services Received

Chronic and/or Serious Medical Conditions:

Past Medical Hospitalizations:

Past Psychiatric Hospitalizations:

Services Received:	Current	Past
<input type="checkbox"/> Therapeutic Behavioral Services (TBS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Intensive Care Coordination (ICC)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Intensive Home-Based Services (IHBS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Therapeutic Foster Care (TFC)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Group Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Specialty Mental Health Services (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wraparound Services (service provider: _____)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Applied Behavioral Analysis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Intensive Services Foster Care (ISFC)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Substance Use Disorder (SUD) Treatment Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Speech and Language Services	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Individual Education Plan (IEP)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Individual Education Plan (IEP)-Educationally-Related Mental Health Services (ERMH)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 504 Accommodation Plan	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/>	<input type="checkbox"/>

Out of County Placement:

County of Jurisdiction:

County of Residence:

Are SMHS Presumptively Transferred? Yes No Waived

Section F. Prior QI Referrals/Additional Considerations

Prior QI Referrals (if applicable):

Date of Referral or Assessment:	County:
Date of Referral or Assessment:	County:
Date of Referral or Assessment:	County:
Date of Referral or Assessment:	County:

Provide any additional information to be considered:

Section G. Minimum Documentation Required to Initiate QI Assessment

Documents identified below are required and must accompany the QI Referral form.

Placing Agency Case Worker

Mental Health Plan Clinician

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Signed Release of Information forms <input type="checkbox"/> Signed Consent to Treatment forms <input type="checkbox"/> Child Welfare/Juvenile Probation Case Plan- including permanency plan <input type="checkbox"/> Needs and Services Plan from current placement provider (if applicable) <ul style="list-style-type: none"> <input type="checkbox"/> Most Recent Completed CANS to be provided by the appropriate agency's staff | <ul style="list-style-type: none"> <input type="checkbox"/> Most Recent Mental Health Assessment (completed in the last 12 months) <input type="checkbox"/> Most Recent Mental Health Treatment Plan |
|--|--|

Explanation is required for any document named above not submitted with the QI Referral form.

Document	Explanation

Section H. Minimum Documentation Required to Initiate QI Assessment

- Materials below must be provided to the QI prior to completion of the Assessment.
- The placing agency caseworker, MHP clinician, and the QI should collaborate on gathering any documentation not available at the time the QI Referral is submitted.

Placing Agency Case Worker

- List of services that have been provided to preserve the current placement, including child welfare funded services and interventions.
- CFT recommendations (if applicable)
- JV 220 (if applicable)
- Psychological Evaluations
- Any current family visitation orders including no contact orders.
- Education information including current IEP or 504 plan if applicable (Health and Education Passport).
- Placement History including successful placements and services printed out from CWS/CMS-full history.
- Medical history including medical hospitalizations (Health and Education Passport)
- Developmental Assessment if applicable including documentation related to both being assessed for and receiving services authorized through a Regional Center or provided by a Regional Center vendor.
- Juvenile Probation specific assessments and latest social studies report

Mental Health Plan Clinician

- List of services that have been provided during the prior 12 months (at minimum), including wraparound and Specialty Mental Health Services
- Psychological Evaluations
- History of Psychiatric Hospitalizations

- Documents identified above are required and necessary for the QI to complete their Assessment.

Referral for Qualified Individual Assessment – Instructions

This form is used to request a Qualified Individual (QI) Assessment be completed for a child or youth being considered for placement in a Short-Term Residential Therapeutic Program (STRTP) or Community Treatment Facility (CTF). Complete all sections of this form in full.

Child/Nonminor's Information

Child/NonMinor's Name and Date of Birth: Complete all information in full

Case Type: Select from 602 Ward, Dual Jurisdiction, Family Maintenance; Family Reunification, Permanent Plan, Pre-Disposition (Probation Cases) *{possibly align options with "service components" from CWS/CMS}*

Court ID# In CWS/CMS, in existing Client Notebook (blue button), on Juvenile Court Number Tab

Medi-Cal Client ID# In CWS/CMS, in existing Client Notebook, on ID tab, next to SSN

Section A.

Date Referral Submitted: Enter date the Referral form is transmitted to the QI.

Referral Submitted Prior to Placement in STRTP? Mark "yes" or "no"

Date Child Placed in STRTP: If Referral is submitted *on or after* the date child is placed in an STRTP (emergency placement), enter the date of placement in the STRTP

QI Assessment Report Due Date: 30 calendar days following the Date Referral Submitted or, if Emergency Placement, 30 days following date of placement in STRTP, whichever is sooner.

Reason for Referral: Check box next to reason(s) for referral.

Rationale for QI Referral: Describe why the child/youth's needs require an STRTP level of care.

Section B.

Contact Information: Complete all information in full

Section C.

Current Caregiver: Complete all information in full

Section D.

Members of the Child and Family Team: Complete all information in full

Section E.

Health Information & Behavioral Health Services Received:

Identify chronic and serious medical conditions. Enter dates of prior medical and psychiatric hospitalizations.

Services Received: Mark the box of all services youth has a record of having received. For each service checked, mark the "Current" or "Past" box to indicate when the youth received the service.

County of Jurisdiction:

County where dependency or delinquency status of the child was established by the court

County of Residence:

County where the child resides

Are SMHS Presumptively Transferred:

Indicate if SMHS are transferred or waived

Section F.

Prior QI Referrals/Additional Considerations:

Enter the date and county of prior QI Referrals and completed QI Assessments

Additional Information to be Considered:

Describe additional information that is important for a QI to consider but is not reflected in other sections of the Referral form.

Section G.

Required Documents:

Documents listed in section G must accompany Referral form

Explanation is required for any document listed in Section G that is not attached to Referral form.

Section H.

Additional Documents

Documents listed in Section H must be submitted to the QI prior to completion of the QI Assessment.