Child Welfare Services
Referral for Mental Health Treatment
Assessment, Individual, Conjoint, or Group

Instructions for SW:

- Complete all pages - one form per individual and service.
- Review the Parent or Child/Youth Therapy Flow Charts to ensure that a TERM referral for services is appropriate.
- Ensure that there is not already a current authorization in place for the service.

A. PSW/PSS INFORMATION

Date submitted to JELS Clerk: **Region/Centralized Program:** <select>

Name of SW: **Phone #:** **SW Email:** @sdcounty.ca.gov

PSS Name: **Phone #:** **PSS Email:** @sdcounty.ca.gov

PSS Signature: ________________________________

Note To Provider: If you are unable to locate the SW with information provided above, call Hotline Records at (858) 514-6995 and provide code "BHS2021" to obtain SW information.

B. CASE INFORMATION

☐ Voluntary ☐ Pre-Jurisdiction ☐ Court-Ordered Case Status: <select> Next Court Date:

To avoid conflicts of interest, list full legal names of family involved in case plan and relationship to child:

	Legal Name	Relationship to Child/Youth		Legal Name	Relationship to Child/Youth
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

CHECK ALL THAT APPLY:

☐ **A CHILD IN THIS CASE IS UNDER 3 YEARS OF AGE:** W&I Code 361.5 (a)(2) limits reunification services in these cases to 6 months. However, W&IC 366.21(e) permits services to be extended up to six additional months if it can be shown that there is a substantial probability that the child will be returned to the parent/guardian by the end of that time.

☐ **Highly Vulnerable Child(ren) Case:** A higher-than-average possibility exists of serious re-injury or death to a child. Cases may include the following:

- Severe physical abuse, and serious non-accidental injuries to the head, face or torso in children age five (5) years or younger, or children who are developmentally delayed at a functional level of five years or younger
- Child's parent or guardian caused the death of another child through abuse or neglect
- Infant born to parents currently involved with CWS or past involvement with CWS and did not successfully reunify

☐ **Parent had a previous CWS case for: (check all that apply)**

☐ Domestic Violence ☐ Emotional Abuse ☐ General Neglect ☐ Severe Neglect ☐ Physical Abuse

- In previous case, parent <select>

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C. CHILD/YOUTH – REFERRAL INFORMATION

Legal Name: **DOB:** **State ID #:** **Two Digit Person #:**

Gender: <select> **Pronoun(s):** <select> Comment**:**

Language: <select> **Ethnicity:** <select> If "Other," specify:

If service is to be provided in a language other than English, specify language: <select>

Current grade: **School:**

IEP: ☐ Yes ☐ No If Yes, specify the qualifying condition:

Current Placement: <select>

Parent/Caregiver Name: **Language:** <select>

Address: **Phone Number:**

Therapeutic Intervention requested for child/youth: <select>

REASON(S) FOR REFERRAL:

☐ **CANS –** Child/youth has a CANS score of 1, 2 or 3 on any item on the Behavioral/Emotional Needs Domain
Date of CANS/CFT:
If a prior CANS referral was made, what was the date of the first referral?

☐ **Serious Emotional Damage.** A petition has been, or will be, filed under Section 300(c) (Serious Emotional Damage) and CWS would like a licensed mental health professional to assess for the effects of abuse and/or neglect on the child.

☐ **Child/youth is a sexual abuse victim or has witnessed or otherwise been exposed to age-inappropriate or adult sexual behavior.**

☐ **Emotional Abuse** due to exposure to domestic violence.

☐ **Severe Emotional Abuse, Physical Abuse, and/or Neglect.** Child/youth may have been tortured. Specific allegations/true findings :

☐ **Emotional Abuse, Physical Abuse, and/or Physical Neglect.** Child/youth is either living with biological parent or with substitute caregiver (e.g., resource parent, NREFM) and there are behavioral and/or emotional issues.

☐ **Adoption/Termination of parental rights.** The child/youth will not be reunifying with the parent(s). An opportunity to process grief/loss issues is appropriate.

☐ **Child/youth recently changed placement.** An opportunity to process grief/loss issues is appropriate.

☐ **Prior therapist terminated services prior to the completion of therapy.**

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☐ **The child/youth exhibits significant behavioral concerns:**
- ☐ Self-harming behaviors and/or suicidal ideation, plan, and/or past suicide attempts
- ☐ Sexual Behavior Problems (SBP)
- ☐ **VERIFIED** willful cruelty to animals
- ☐ Physical aggression toward peers and/or caregivers

☐ **Conjoint Therapy** is recommended by Child/Youth's Therapist or SW to facilitate child/youth's therapeutic healing process.

List all additional service recipients for conjoint therapy: <selection required>

Select the Treatment Modality and CPT Code**:**

For conjoint treatment referrals:

Mother successfully completed group treatment: ☐ Yes ☐ No ☐ N/A
List completed services:
Mother's therapist states parent is clinically ready for conjoint therapy ☐ Yes ☐ No ☐ N/A

Father successfully completed group treatment: ☐ Yes ☐ No ☐ N/A
List completed services:
Father's therapist states parent is clinically ready for conjoint therapy ☐ Yes ☐ No ☐ N/A

Child/youth's therapist states child/youth is clinically ready for conjoint therapy: ☐ Yes ☐ No ☐ N/A

☐ Service is court ordered (contrary to a CWS recommendation) Date of court order:

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D. PARENT - REFERRAL INFORMATION

Legal Name: **DOB:** **State ID #:** **Two Digit Person #:**

Gender: <select> **Pronoun(s):** <select> Comment:

Relationship to Child/Youth: <select> Comment:

Language: <select> **Ethnicity:** <select> If "Other," specify:

If service is to be provided in a language other than English, specify language: <select>

Address: **Phone Number:**

☐ Parent is homeless Zip code where parent is most frequently located:

Date by which parent must demonstrate substantial progress in services:

Parent: ☐ Denies allegations/true finding ☐ Accepts responsibility/true finding

REASON FOR REFERRAL:

☐ **GROUP TREATMENT - Select type of Group and CPT code for the Group Treatment**

☐ Domestic Violence (☐ offender **or** ☐ victim) CPT Code: <selection required>

☐ Sexual Abuse (☐ offending parent **or** ☐ non-protecting parent) CPT Code: <selection required>

☐ Child Abuse Group CPT Code: <selection required>

Parents referred for Group Treatment receive a one-time mental health assessment that includes suitability for the group. SW must follow up with the provider after the Initial Assessment to confirm eligibility.

☐ **INDIVIDUAL OR CONJOINT THERAPY – Select all of the reasons that apply:**

☐ **Individual treatment to address the group therapy content**. Group facilitator has determined that the parent is not appropriate for group treatment and recommending individual therapy in lieu of group to address the group therapy content/curriculum.

☐ **Individual treatment to address mental health or Serious Mental Illness (SMI).** Parent's mental health directly relates to safety/risk factor(s), is identified as a need in the CANS (Caregiver/Resources Domain), and is a planned client service to meet the objective(s)/safety goal(s) in the Case Plan. For parents who suffer from documented history of SMI, a development of relapse prevention plan is indicated, **and** parent has a psychiatrist and is stable on medications.

Describe the mental health/SMI concerns:

☐ **Individual treatment because SW Suspects mental health concerns.** Parent does not have a diagnosed history of mental illness but self-reports symptoms of depression, self-reports suicidal or homicidal ideation, **and/or** other significant mental health concerns (e.g., severe hoarding, hearing voices) that impacts or interferes with parent's case plan progress.

Describe the mental health concerns:

☐ **Individual Treatment is recommended in consultation with PSS, CWS Staff Psychologist, and/or other treatment providers (e.g., substance abuse counselor, group therapy facilitator):** Parent active to substance abuse treatment. Group therapy facilitator is recommending individual therapy in addition to the

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group treatment; treatment recommendations include individual therapy for these specific reasons/issues:

☐ **Domestic Violence Conjoint Treatment AFTER** successfully completing DV offender or DV victim group therapy ☐ **Conjoint Treatment is recommended by Child's Therapist or SW** to facilitate child's therapeutic healing process. In Conjoint Therapy, client information pertains to the child/youth. Ensure that the Conjoint Therapy box is checked in the

☐ **Service is court ordered** (contrary to a CWS recommendation) Date of court order:

Select the Treatment Modality and CPT Code: <selection required>

E. REASONS FOR CWS INVOLVEMENT

Date of the incident that resulted in current case:

Safety Threat(s) identified at onset of case (SDM Safety Assessment): Check all that apply

☐ Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm.

☐ Child sexual abuse is suspected, AND circumstances suggest that the child's safety may be of immediate concern.

☐ Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.

☐ The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

☐ Caregiver describes or speaks to the child in predominantly negative terms or acts toward or in the presence of the child in negative ways AND these actions result in severe psychological/emotional harm, leading to the child being a danger to self or others.

☐ Other (specify):

☐ Caregiver is unable OR unwilling to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.

☐ Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, AND the nature of the injury suggests that the child's safety may be of immediate concern.

☐ The family refuses access to the child, or there is reason to believe that the family is about to flee.

☐ Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.

Describe the incident and safety/risk factors (i.e., protective issue(s)) that brought this family to CWS's attention:

Harm Statement(s):

Danger Statement(s):

Safety Goal(s):

Describe what is going on in the case right now, including reason for the child/youth or parent being referred:

Describe the parent's Case Plan participation and progress with meeting the Safety Goal(s):

F. INFORMATION REQUIRED TO ESTABLISH PROVIDER MATCH

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Mental health services will be provided in: ☐ San Diego County ☐ Other:

Funding Source: ☐ Medi-Cal County of San Diego Medi-Cal Number: Issue Date:

☐ CWS Funds

☐ Child/youth or parent has private insurance:

Telehealth

☐ Child/youth or parent is willing and able to participate in tele-health AND they have the appropriate technology to participate, i.e. phone/computer with internet access (this is not a guarantee they will receive tele-health)

☐ Tele-therapy is specifically requested for this child/youth or parent for the following reason(s):

Are you requesting reassignment from the previously assigned provider? Yes ☐ No ☐

- If yes, what is the reason for the reassignment?
- If yes, what was the previous provider's name?
- If yes, do you want Optum to end the previous provider's authorization?

TERM Provider requested :

If specific provider requested, SW has confirmed with the provider that they are able to serve this child/youth or parent: Yes ☐ No ☐

Other agencies/professionals providing services to the child/youth, parent, or family system: ☐ N/A

Transportation issues/limitations: ☐ N/A

Scheduling preferences: **Past and/or current restraining orders (e.g., TRO, CPO, RO):**

Has the parent threatened CWS staff or others: Yes ☐ No ☐ If yes, describe:

Describe specific mental health concerns for the parent:

Current and past mental health diagnoses given by licensed mental health providers:

Current and past mental health treatments:

Current and past substance abuse/dependence:

Current and past medication(s):

Level of motivation/compliance regarding this service:

G. NON-TERM PROVIDER

Complete this section if requesting a non-TERM provider (check as many as applies)

☐ **Child/youth or parent has needs that cannot be met through TERM panel. Specify below:**

Language:

Cultural:

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Clinical:

Other:

☐ **SW requests approval of child/youth or parent's current or past therapist to address protective issues:**

Name of therapist: Phone Number:

E-mail Address:

☐ **Parent resides outside San Diego County but:** ☐ within California ☐ outside California

☐ **Child/youth or NMD resides out of county, in California, and Presumptive Transfer was waived.**

☐ **Child/youth or NMD resides out of county, in California, and Presumptive Transfer has occurred but this youth does not meet medical necessity criteria to receive Specialty Mental Health Services, however child/youth and/or Child and Family Team has assessed a need for therapeutic service**.

****ACTIONS REQUIRED FROM SW****

After completing the form:

- Submit the 04-176A to Regional JELS Staff to submit to Optum TERM
- Send case records to the provider once they have been confirmed as per the Policy Manual: Mental Health Treatment to include court reports, court orders if relevant, psychological evaluations, prior mental health records, etc. Please confirmed delivery method of case information (mail or fax) DIRECTLY with the assigned provider before sending case documents.

Optum TERM will forward to provider with the CWS authorization. For follow-up questions, please call Optum at 1-877-824-8376.