HUMBOLDT COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH
1243 – CONTRACT PROVIDER SMHS REFERRAL FORM

Client Name:		**Date of Referral:**
Client address:		**Client DOB:**
Client Social Security Number:	**Legal Guardian:**	
Medi-Cal #:	**Client/Guardian Phone:**	
County of Origin:	**Host County:**	**Client ID#:**

Client is currently receiving these services from this agency:

☐ Targeted Case Management Agency: _____
☐ Intensive Care Coordination (ICC) Agency: _____
☐ Specialty Mental Health Services (SMHS) Agency: _____
☐ Medication Support Agency: _____
☐ Intensive Home-Based Services (IHBS) Agency: _____
☐ Therapeutic Behavioral Services (TBS) Agency: _____
☐ Therapeutic Foster Care (TFC) Agency: _____

Services Referred For:

☐ Targeted Case Management Agency: _____
☐ Intensive Care Coordination (ICC) Agency: _____
☐ Specialty Mental Health Services Agency: _____
☐ Medication Support Agency: _____

Referrals for IHBS, TBS, and TFC require a separate authorization

Level 1 ☐ Severe **Level 2** ☐ Moderate **Level 3** ☐ Mild

Primary/Provisional Diagnosis (Optional)**:**

Clinical rationale for services requested. Describe specific functional impairments related to the diagnosis:

Copies of clinical documentation attached: ☐ Yes ☐ No **Sent by** ☐ Fax ☐ Mail ☐ Email

Referring Person: (print): _____

(signature): _____ Date: _____

Clinical Supervisor: (print): _____

(signature): _____ Date: _____

Referring Agency/Program: _____ Phone: _____ Fax: _____

Date Referral was sent to Provider: _____ **Sent by** ☐ Fax ☐ Mail ☐ Email