Optum TERM Mental Health Referral for Children/Youth/NMD:
REFERRAL FORM

SWs must complete the 04-176A for a child/youth meeting one or more of the following criteria for Optum TERM oversight

1. 300 (e, f, i)
2. Highly Vulnerable Child (HVC)
3. The primary reason for CFWB involvement is physical or sexual abuse.

NOTE: If child/youth/NMD presents with emotional or behavioral dysregulation which impairs the child/youth/NDM's daily functioning across multiple domains (e.g., social, physical, cognitive, behavioral/emotional) and may include self-harming behaviors, tantrums, impulsivity, a referral may be appropriate for Optum TERM. Consult with Staff Psychologist as needed.

A. PSW/PSS INFORMATION

CFWB Office/Program: <select>

Name of SW:		Phone Number:		SW Email:	
PSS Name:		PSS Phone number:		PSS Email:	

Assigned/Covering 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. CHILD/YOUTH/NMD – REFERRAL INFORMATION

Last Name:		First Name:	
Preferred Name:		DOB:	
State ID:		Two Digit Person No:	
Gender:	<select>	Pronoun(s):	<select>
Language:	<select>	If "other" language specify:	
Ethnicity:	<select>	If "Other" ethnicity specify:	
If service is to be provided in a language, include the language here:			

Current Placement:	<select>	Name of current caregiver & relationship to child:	
Address including zip code:		Caregiver Phone Number:	
Cultural Considerations (Include gender identity, sexual orientation, and any cultural or other considerations to support appropriate provider matching and address the youth's individual needs)			

C. FUNDING INFORMATION

Mental Health services will be provided in	☐ San Diego County	☐ Other County. If another county in CA, name here:
If the child/youth reside outside of San Diego County, but within CA, and the child/youth is in out of home care, presumptive transfer applies. If outside of CA, ICPC applies.		
Medi-Cal Number or CIN number		**Issue Date**
EMAIL: FC-Clerical.HHSA@sdcounty.ca.gov for Medi-Cal Information for children/youth. **OR**		
☐ SW verified if the youth/child/NMD has private insurance, TRICARE or other Non-Medi-Cal insurance.		

D. FAMILY INFORMATION

To avoid conflicts of interest, list legal names of the family members who will be receiving treatment through Optum TERM and children who are involved on the case plan.

Legal Name / Alias	Relationship to Child/Youth/NMD	DOB
1. /		
2. /		
3. /		
4. /		
5. /		
6. /		
7. /		

E. CASE INFORMATION

Case Status: <select>	Highly Vulnerable Child Case <select> For the purposes of provider assignment. Interns cannot be assigned if case is HVC.

TYPE OF SERVICE THERAPY REQUESTED (One therapy request per form):

☐ Individual	☐ Conjoint with the parent/caregiver (For pre-verbal children select this option)

*Conjoint therapy with a case involved parent may be considered when the parent has successfully completed their own group treatment or at the recommendation of the individual therapist, **and** treatment is needed to address safety/risk factors.*

SERVICE DELIVERY METHOD

☐ In-person treatment is preferred if available.
☐ Telehealth is appropriate. See CFWB TELEHEALTH CRITERIA for guidance.

Primary Reason for CFWB Involvement or Reason for Referral (e.g. change of placement/adoptions case):

☐ Exposure to domestic violence/IPV
☐ Severe emotional abuse
☐ Sexual abuse victim
☐ Witnessed or otherwise been exposed to age-inappropriate or adult sexual behavior
☐ CSEC
☐ Physical abuse
☐ Severe neglect
☐ Behavioral and emotional concerns
☐ Adoption/termination of parental rights
☐ Child/Youth recently changed placement

Mental health concerns for the youth (e.g. sadness, anxiety, self-harming, suicide ideation, sexual behavior concerns physical aggression towards others, verified willful cruelty to animals, recent psychiatric hospitalizations) if known:
Additional information including complicating factors: (e.g. intellectual disability, neurodiversity needs, SUD):
Include any known diagnoses (e.g. Autism Spectrum Disorder): ☐ N/A
Child/Youth Strengths (e.g. protective capacities, skills, interest):

F. SCHEDULE AND TRANSPORTATION CONSIDERATIONS

Optum will attempt to accommodate limitations, but cannot guarantee scheduling preferences.

Transportation Limitations:		☐ N/A
Scheduling Limitations:		☐ N/A

G. REASSIGNMENTS OR SPECIFIC PROVIDER REQUEST (IF NOT APPLICABLE LEAVE BLANK)

Reassignment Request

• Provider's name with active authorization	
• What is the reason for the reassignment?	
• Do you want Optum to end the previous provider's authorization?	

Name of specific TERM provider requested:
If specific provider requested, SW has confirmed with the provider that they are able to serve this child/youth or parent: Select one

ACTION REQUIRED BY SW: Submit the 04-176A to Office JELS Staff to submit to Optum TERM

Once assigned, send relevant documentation to the provider to support client treatment (e.g., JD report, status reviews, addendums, case plan, and mental health history)