Kings County Mental Health Services

- Kings County Behavioral Health
  460 Kings County Dr. #101. Hanford, CA 93230
  Phone: (559) 852-2444
  (Referral Attached)

- Kings View Counseling Services
  1393 Bailey Dr. Hanford, CA 93230
  Phone: (559) 582-4481
  {Walk-In Hours}
  Monday-Friday (Except Tuesday's)
  8:00AM-2:00PM
  Crisis Number's: (559) 582- 4484 & 1-800-655-2553

- Aspiranet
  530 Kings County Dr. #104. Hanford, CA 93230
  (Referral Attached)
  (Authorization for services from KCBH)

Other Mental Health Services

Hanford

Adventist Behavioral Health
1025 N Douty St Hanford, CA 93230
(559) 537-0246

Family HealthCare Network
250 W 5th St. Hanford, CA 93230
(877) 960-3426

Kings Counseling Center
808 N Irwin St. Hanford CA 93230
(559) 584-2819

Corcoran

Kings View Counseling Services
Corcoran CA 93212
(559) 992-2833
*Must Complete Assessment in Hanford First

United Health Centers
1209 Whitley Ave, Corcoran, CA 93212
(559) 992-5476

Avenal & Kettleman

Kings View Counseling Center
228 E Kings St, Suite E. Avenal, CA 93204
(559) 386-2295
*Must Complete Assessment in Hanford First

Aria Community Health Center
1000 Skyline Blvd. Avenal, CA 93204
(559) 386-4501

Avenal Medical Clinic
148 E Kings St. Avenal, CA 93204
(559) 386-9000

Lemoore & Stratford

Aria Community Health Center
140 C St. Lemoore, CA 93245
(559) 924-7005

United Health Centers
1270 N Lemoore Ave. Lemoore, CA 93245
(559) 924-2015

Referral **Form**

460 Kings County Drive, Suite 101

Hanford, CA 93230

Phone: (559) 582-3211 Ext. 2376

FAX: (559) 589-6928

Children/Youth Referral and Authorization form for

FULL SERVICE PARTNERSHIP WRAPAROUND

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Instructions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

REFERRAL INFORMATION

Date: _____ Preferred Language:_____

Child/youth First Name: _____ Child/youth Last Name:_____

DOB: _____SSN: _____Race/Ethnicity:_____

Gender: □ Female □ Male □ Transgender □ Gender nonconforming □ Other

Address: _____City:_____ ZIP Code: _____

Phone Numbers: _____Current Living Arrangement: _____

Insurance: □ Medi-Cal □ Private □ None □ Other _____

Primary Contact:_____ Relationship : _____

Preferred Language: _____ _ Phone: _____

Conservator? □ No □ Yes whom? :_____

REFERRAL SOURCE

Referral Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ Email: _____

Is child/youth currently receiving services from referral agency? □ Yes □ No

Other Agencies Involvement: □CWS □Probation □Kings View □CVRC □Other _____

If child/youth was referred to any other programs, please identify:

_____

_____

_____

Child/Youth Name: _____

FOCAL POPULATION

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Check appropriate reason(s) for referral of a Child with Serious Emotional Disturbance (SED) *

1. Zero to five –year-old (0-5) who:
   - ☐ is at risk of expulsion form pre-school
   - ☐ is involved with or high risk of being detained by Child Welfare System (CWS)
   - ☐ has a parent/ caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorder

2. Child/youth who:
   - ☐ has been removed or is at risk of removal from their home by CWS
   - ☐ is in transition to a less restrictive placement

3. Child/Youth is experiencing the following at school:
   - ☐suspension or expulsion
   - ☐violent behaviors
   - ☐drug possession or use
   - ☐suicidal and/or homicidal ideation

4. Child/youth who:
   - ☐ is involved with probation, and/or is on psychotropic mediation, and/or has transitioned back into less structured home/community.

Provide detail for any checked item:

_____

_____

_____

_____

**A child/youth is considered seriously emotionally disturbed (SED) if he/she exhibits one or more of the following characteristics, over a long period of time and to a marked degree, which adversely affects his/her functioning:*

(1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;

(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

(3) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations;

(4) A general pervasive mood of unhappiness or depression;

(5) A tendency to develop physical symptoms or fears associated with personal or school problems.

[34 C.F.R. Sec. 300.7(b)(9); 5 Cal. Code Regs. Sec. 3030(i).]

Child/Youth Name: _____

LEVEL OF SERVICE

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CHECK ONE ONLY:

☐Unserved (Not receiving mental health services)

☐History of mental health services, but none currently ☐ No prior mental health services

☐ Underserved (**Receiving some mental health services, though insufficient to achieve desired outcomes**)*

☐ Inappropriately served (Receiving some mental health services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the consumer)*

*****If client has received community based mental health services within the last 6 months, 1) identify the programs; 2) indicate the type and frequency of services; and 3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATION

Primary DSM V Diagnosis (if applicable): _____

Substance Use Disorder Diagnosis (if applicable):_____

Check all that applies to individual:

☐ Aggressive Ideation
☐ Aggressive Act (by history or current)
☐ Aggressive Threats (by history or current)
☐ Fire Setting or Acts
☐ Inappropriate Sexual Acts
☐ Other: _____
☐ Inappropriate Sexual Ideation
☐ Psychiatric Hospitalizations (indicate dates below)
☐ Suicidal Ideation/Attempts
☐ Symptoms of Psychosis
☐ Tarasoff Notifications (past or current)

Provide Detail for Any Checked Items:

_____

_____

_____

_____

FAX complete form to Kings County Behavioral Health Attention: Children System of Care Program Manager at: (559) 589-6928 bhinfo@co.kings.ca.us

Child/Youth Name: _____

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DISPOSITION

To Be Completed by KCBH

Date received _____

☐ Not pre-authorized for Enrollment (Explain reasons for decision and plan for linkage to other services):

_____

_____

_____

☐Pre-authorized for Enrollment:
Name of FSP Agency: _____ Phone: _____FAX:_____

Contact Person: _____ Phone: _____

KCBH Authorizing Representative: _____ Date: _____

To be completed by FSP Representative

Date Received: _____

FSP Agency has completed outreach and engagement and (check only one box below):
First face to face contact Date:_____

☐Request Authorization to enroll

☐Agency declines to enroll, but individual is eligible for FSP (Must complete Appeal Form)

☐Individual does not agree to services (explain reasons for decision and plan for linkages)
_____

_____

☐Individual is deemed ineligible for FSP Services (explain reasons and plan for linkages)
_____

_____

FSP Agency Representative: _____ Date: _____

To Be Completed by KCBH

Date Received: _____
☐ NOT AUTHORIZED FOR ENROLLMENT (explain Reason for decision): _____

☐AUTHORIZED FOR ENROLLMENT
KCBH Representative: _____ Date: _____

REFERRAL SOURCE NOTIFIED OF DISPOSITION ON _____ BY _____