Presumptive Transfer Notification Checklist

AB1299 became effective July 1, 2017, which requires a request for presumptive transfers for minors placed in counties outside of their original jurisdiction. For more information on the requirements for implementation of presumptive transfer for foster children placed out of county, please refer to the All County Letter (ACL 17-77).

We would gladly consider serving the individual you would like to refer. However, in order to do so, we would need a request for presumptive transfer from the placing agency along with the following information:

- Identifying information about the child: name, date of birth, CIN # and/or SS# and address;
- Name, location, and contact information of the referring placing agency;
- Name and contact information of who can sign releases of information;
- Name and contact information of who can sign consents;
- The most recent consent for services, and consent for medication, including the JV-220; and
- The most recent mental health records, including the most recent mental health assessment.

The following page contains a checklist that you can use to provide some of the information requested. Once you have completed the checklist and obtained the required documents, the information can be faxed to Utilization Management at: 209-558-4316.

Presumptive Transfer Notification Checklist

All notifications of Presumptive Transfers require the following information:

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Date of Notification of Presumptive Transfer: _____

Identifying Information About the Child:

Name:	
Date of Birth:	
CIN # and/or SS#:	
Address:	
Date Placed in Stan. Co.:	
County of Origin:	

Information Regarding the Referring Placing Agency:

Name of Referring Placing Agency:	
Name and title of Referring Placing Agency Representative:	
Address of Placing Agency:	
Phone and Fax for Placing Agency Representative:	Phone #: Fax #:

Contact Information of Who Can Sign Release of Information Forms:

Name of individual who can sign Release of Information forms:	
Address:	
Phone and Fax:	Phone #: Fax #:
Relationship to Foster Child:	

Contact Information of Who Can Sign Consents:

Name of individual who can sign Consent forms:	
Address:	
Phone and Fax:	Phone #: Fax #:
Relationship to Foster Child:	

Send or arrange to have sent to Stan. Co. **Most recent mental health records, including:** □ Most recent consent for services □ Most recent consent for medications, ○ JV-220, if applicable □ Most recent mental health assessment	Preferred Additional Documentation. □ Consent to Treat- (Review, Sign, Return w/PT) Placing Agency Representative Signature Date

Stanislaus County, Behavioral Health & Recovery Services

CONSENT FOR SERVICES

I authorize and consent for Stanislaus County Behavioral Health and Recovery Services and its contracted service providers (henceforth BHRS) to provide integrated behavioral health services, which may include mental health services and/or alcohol and drug services. All mental health and alcohol and drug records are housed in the same medical record. Information is only to be released in accordance with applicable federal (42 CFR Part 2) and state (W&I code, sect. 5328; Civil code 56.10 seq.) regulations.

I consent to participate in the assessment of my need for specific treatment services.

I agree to involvement in the development of my treatment plan and to discuss treatment options and to participate in specific treatment services and activities as arranged in that plan. I have the right to know of any third party payer requirements, restrictions, or covenants that could interfere with or influence service recommendations. I understand that I can receive a copy of my treatment plan if I wish.

I understand that I have the right to be informed about specific services and procedures, including information about risks, benefits, and alternatives to each service proposed for my treatment. My initial treatment plan and/or services have been explained to me by _____on _____ I understand that there is an expectation that I will benefit from these services but that there is no guarantee that this will occur. I will periodically discuss my progress with treatment providers.

I understand that I have the right to refuse or discontinue any service or procedure. In cases where treatment has been ordered by a court I may still refuse to participate in recommended treatment however there may be legal consequences from failure to follow the court ordered treatment. In the case of a minor or when incompetence exists, the legal guardian has the right of refusal. It is best if my legal guardian or I discuss my treatment with treatment providers if the issue of refusal should arise.

I understand that my participation includes appointments with behavioral health professionals and that maximum benefit can only occur with consistent attendance and my active involvement in the treatment process.

I understand that as the need arises, Tele psychiatry services may be provided to ensure timely access to psychiatric care. Tele psychiatry is the use of two-way real time-interactive audio and video between a psychiatrist and a client in order to provide psychiatric care when the participants are in different geographical locations.

As an important part of my treatment, I understand that I may be asked to voluntarily have my urine tested from time to time. The purpose of such a test would be to help my care providers assure that I am in compliance with my part of the treatment plan and to ensure that the treatment plan is appropriate and safe for me.

I understand that in the event that I fail to keep appointments and remain out of contact, services may be discontinued or interrupted.

I understand that there will be charges for services that I receive. I agree to work with the BHRS financial office to ensure appropriate billing. If I am to pay all or a portion of the fees, I understand that payment is expected at the time of service.

I understand that I have the right to confidentiality, which means that whatever I tell treatment providers will not be repeated by the provider to anyone else without my expressed permission (i.e. by written release).

I understand that there are some exceptions to complete confidentiality. The most common ones are:

a. Providers are required by law to report any known or suspected cases of child, elder, dependent adult or disabled person abuse to the appropriate state agency.
b. If a provider learns that someone is about to do harm to someone else, the provider will be obligated to protect the intended victim either by warning the victim and/or possibly by notifying the appropriate law enforcement authorities, based on current state laws.
c. If a provider learns that you intend to harm yourself, the provider may release information to the extent necessary for your protection.
d. In the case of a medical emergency (i.e., a heart attack), the provider will release any medical information necessary for proper treatment.
e. You will be considered a client of BHRS.
   We provide services by way of a team approach.
   To facilitate coordination of care, diagnosis, treatment, and referral, your care providers may communicate with other care providers within the BHRS as well as with your treating physician. Ordinarily services will be provided by a small number of individuals who are interdependent on other staff members. Others may be involved in roles such as providing services review, quality assurance, specialty/expert opinion, emergency coverage, vacation coverage, and billing. If there is some special circumstance in which you have a prior relationship with any staff member of this agency, please inform your provider so that we can protect that relationship and your privacy to the extent possible.
f. If you are not seeing a licensed or certified provider then it is expected that they will periodically discuss your services with their clinical supervisor. Occasionally, it is in your best interest for your licensed provider to consult with other providers regarding services provided. In cases where consultation with, or referral to, another provider outside BHRS is required, then your written consent will be obtained.
g. Insurance companies and other third party payers require information from your medical record (often including your diagnosis and services provided) in order to process claims. This is understood to include Medical Record audits by your insurance company(ies), third party payer(s), and, if they find reason to question services performed, a comprehensive medical record review.
h. When a court orders production of records or disclosure of privileged communication, copies of relevant information may be provided.
i. A report will be made to the health department when it is suspected that you have a communicable disease that requires reporting to the health department by state law.
j. When you use your mental health condition as part of a legal claim or defense, information may be released to a court of law or judge.
k. When hospitalization for mental illness is necessary, relevant information may be provided for continuity of care, as it is in your best interest.
l. When you are seen for a court-ordered evaluation, results will be released.
m. Information from your record may be used in a confidential manner for research and/or program evaluation.

I understand that all the individuals participating in treatment are expected to conduct themselves in an appropriate and respectful manner, and to protect the confidentiality of fellow clients. I understand that any aggressive, violent, or threatening behavior or violation of confidentiality may be the basis for exclusion from all or some services.

I understand that this consent for services is effective for the duration of my treatment at BHRS unless expressly revoked.

I have read and understand the above and request and authorize BHRS to evaluate and/or treat

Signatures

Print Client Name	Client Signature	Date
Print Parent / Legal Guardian Name	Parent / Legal Guardian Signature	Date
Print Staff Name	Staff Signature	Date