Home Start

Behavioral Health Referral Form

Behavioral Health Services
619-692-0727 Ext. 139
E-mail: BH@home-start.org
Fax 619-692-0785

Date of Referral:

Primary Caregiver Name: (If Client's a minor)	**Primary Client's Name (Child's name in most cases):**
Primary Caregiver DOB: (If Client's a minor)	**Client's Date of Birth and Gender:**
Street Address	Referrer's Name and Organization
City Zip Code	Address
Email:	City Zip Code
Phone #:	Phone # Fax#
Preferred Language / **Family's Ethnicity**	**When is client available for sessions:** **(Best Days & Times)**

Is this child a dependent of the Court? Yes No
If yes, please provide social worker's name and contact:

Referral Comments: (ex: Concerns, Legal Custody, Diagnosis, etc.)

Does client have any disabilities? (circle answers)

None Speech Delay
Vision Deaf/Hard of Hearing
Developmental Cognitive/Mental Impairment
Other: ____

Has client experienced any of the following:

Physical Abuse Neglect
Emotional Abuse Teen Dating Violence
Witness to DV Sexual Abuse/Human Traffic
Child Abduction Terrorism/Mass Violence
Vehicular Violence Victim of a Crime
Parental Substance Abuse
School/Community Violence/Hate Crime

IMPORTANT:
Please FAX to Intake Coordinator at 619-692-0785.
Do NOT email due to confidentiality (HIPPA) laws.

CONSENT FOR REFERRAL: (circle answers)
As the referring party, I have received verbal consent from the primary caregiver and/or client to make this referral to Home Start, Inc. **Yes** **No**

Is client comfortable with video sessions (Telehealth)?
Yes **No**

Does client have Medi-Cal or Private Insurance?
Yes **No**

Have they sought treatment through their insurance provider?
Yes No

Reason for seeking treatment through Home Start rather than through insurance:

Long Waitlist Unable to afford co-pay
No provider in their area Transportation Challenges
Bad experiences w/services provider through insurance
No insurance
Other:____