VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Logrando Bienestar Referral

Client Information

Name: _____ DOB: _____ Age: _____ ❑ Female ❑Male ❑Transgender ❑Genderqueer

SSN: NA If client is a minor, please provide guardians full name: _____

Guardians Phone Number: _____ Home Phone: _____

Cell Phone: _____ Verbal consent to leave a phone message: ❑ Yes ❑ No
Best time to contact: ❑Morning ❑Afternoon ❑Evenings

Address: _____ Apt #: _____ City: Oxnard

State: CA Zip: _____ If Homeless, In what city and neighborhood? _____

Payer Source: ❑ Medi-Cal/ Gold Coast ❑Medicare (Age 65+) ❑ Private Insurance ❑ No Insurance
(Medi-Cal number: _____)

Referral Source: _____ **Date:** _____
❑Self ❑Family ❑MD ❑Community Agency ❑APS/CPS ❑ Law Enforcement ❑ School _____

Other: _____ Agency: _____ Phone: _____

Primary Language:
❑ American Sign Language (ASL) ❑ Mixtec ❑ Spanish ❑ English ❑ Other Sign Language ❑ Unknown/ Not Reported

Preferred Language Spoken- Parent/ Guardian/ Caretaker: ❑ American Sign Language (ASL) ❑ Mixtec ❑ Spanish ❑ English ❑ Other Sign Language ❑ Unknown/ Not Reported

Ethnicity: If Hispanic or Latino: ❑ Another Hispanic or Latino Ethnicity: Latina
❑Caribbean ❑ Central American ❑ Mexican/ Mexican American/ Chicano ❑ Puerto Rican ❑ South American
If Non-Hispanic of Non-Latino: ❑ Other _____
❑African ❑ Asian Indian/ South Asian ❑ Cambodian ❑ Chinese ❑ Eastern European ❑ European ❑ Filipino ❑ Japanese ❑ Korean ❑ Middle Eastern ❑ Vietnamese

Race: ❑ American Indian or Alaska Native ❑ Asian ❑Black or African American ❑Hispanic or Latino ❑Native Hawaiian or Pacific Islander ❑White ❑More than one race ❑Another race (please specify): _____

Safety Concerns for Staff: ❑Yes, Why_____

Reason for Referral:

❑Homeless ❑ Danger to others ❑ Suicidal ideation ❑Recent suicide attempt ❑Paranoia ❑Hallucinations ❑Substance abuse ❑Delusion ❑Mania ❑Recent Hospitalization (when &where) _____ ❑ Duration of Symptoms: _____
Other behaviors of concern:

Staff Name: _____ Phone Number: _____ Date: _____

FOR LOGRANDO BIENESTAR STAFF USE ONLY

CA 53 Accessing SMHS Rev 4 (3/12/20) ❑Data Entered in Avatar

Please email Referral form to: Lograndobienestar@ventura.org or Fax to 805-981-4209

Please check if individual is in one or more of these *underserve* populations:

❑Hispanic/Latinx ❑Mixteco ❑Homeless ❑Trauma Risk or Exposure (Child/Youth) ❑Older Adult (60+) ❑African American ❑Transitional Age Youth (TAY) (Ages 16-25) ❑LGBTQ+ ❑Asian Pacific Islander

REFERRING PROGRAM INFORMATION

Provider/Program: ❑ One Step a la Vez ❑ Project Esperanza ❑ Tri-County GLAD ❑ Rainbow Umbrella ❑ COMPASS ❑ VCOE ❑ Promotoras (MICOP) ❑ PYPF ❑ EDIPP ❑ Eating Disorders ❑ Clinicas del Camino Real ❑ PEP ❑ FAF ❑ F&F ❑ IOOV ❑ CIT ❑Logrando Bienestar ❑Other _____

Reason for referral to the programs above:

ALL REFERRALS. Please complete the following for ALL referrals made to <u>Prevention</u>, <u>Early Intervention</u> or other <u>County (funded, administered or overseen) Mental Health treatment programs</u>.

Date written referral was made: _____

Name Program/Organization *<u>RECEIVING</u>* Referral: _____Address: _____

Contact Name: _____Email: _____

Phone Number: _____Additional Information (Hours, special requirements, etc.): _____

Follow-Up Call Information: _____Date client first participated (at least once) in referral program:

Indicate if client did NOT participate and reason why (if known): _____

Did you assist the client with any of the following to access services? No ☐ Yes ☐ If "Yes", please indicate below.

❑Bus Tokens ❑Accompaniment ❑Transportation ❑Translation/Interpreter Services ❑Reminder Calls ❑Other_____

Complete <u>ONLY</u> for referrals to COUNTY Mental Health Treatment Programs <u>NOT</u> Prevention or Early Intervention Services.

Reason for Referral: _____

Approximately how long (in years and months) has the person been experiencing the above? _____

Has individual received previous treatment for this? Yes / No

If yes, approximate and most recent date month/year: _____

NOTES: _____

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