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

Logrando Bienestar Referral

Clear Form

Client Information

Name: _____ DOB: _____ Age: _____ ☐ Male ☐ Female ☐ Other

Contact #: _____ **Consent to leave phone message:** ☐ No ☐ Yes **Best contact time:** ☐ A.M. ☐ Afternoon ☐ P.M.

Address: _____ Apt. #: _____ City: _____

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

If client is a minor, provide parent/guardians name: _____ Contact #: _____

Payor Source:

☐ Medi-Cal/ Gold Coast (Medi-Cal #: _____) ☐ Medicare (Age 65+)

☐ Private Insurance ☐ No Insurance

Referring Party Information:

Date: _____ Referring Party Name: _____ Contact #: _____

☐ Family ☐ MD ☐ Community Agency ☐ APS/CPS ☐ Law Enforcement

☐ School: _____ ☐ Other: _____ Email: _____

Primary Language (spoken at home):

☐ American Sign Language (ASL) ☐ Mixteco ☐ Spanish ☐ English ☐ Other Sign Language

☐ Other Language: _____ ☐ Unknown/ Not Reported

Preferred Language (for services to be given)

☐ American Sign Language (ASL) ☐ Mixteco ☐ Spanish ☐ English ☐ Other Sign Language

☐ Other Language: _____ ☐ Unknown/ Not Reported

Ethnicity:

If Hispanic or Latino:

☐ Caribbean ☐ Central American ☐ Mexican/ Mexican American/ Chicano

☐ Puerto Rican ☐ South American ☐ Another Hispanic or Latino Ethnicity: _____

If Non-Hispanic or Non-Latino:

☐ Middle Eastern ☐ Cambodian ☐ African ☐ Chinese ☐ Filipino ☐ Asian Indian/ South Asian

☐ Vietnamese ☐ Japanese ☐ Korean ☐ Eastern European ☐ Other: _____

Race (select one or more racial designation)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White

Reason for Referral to Logrando Bienestar:

Safety Concerns for Staff: ☐ Yes, Why?: _____ ☐ Homeless ☐ Danger to others ☐ Mania

☐ Suicidal ideation ☐ Recent suicide attempt ☐ Paranoia ☐ Delusion ☐ Substance abuse ☐ Hallucinations

☐ Recent Hospitalization (when &where): _____ ☐ Duration of Symptoms: _____

☐ No unusual history

☐ Data entered in Avatar Pg.1

For Logrando Bienestar Staff Use Only

Please check if individual is in one or more of these underserved 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

Are you a veteran?
☐ No ☐ Yes

Do you consider yourself:
☐ Heterosexual ☐ Bisexual ☐ Gay or Lesbian ☐ Queer
☐ Another sexual orientation (specify):_____ ☐ Questioning/Unsure of sexual orientation

Do you have a disability? *(Disability is defined as a physical or mental impairment or medical condition lasting at least 6 months that substantially limits a major life activity, which is not the result of a severe mental illness)* ☐ No ☐ Yes

If you have a disability, please select all that apply:
☐ Chronic health condition/chronic pain
☐ Developmental disability ☐ Physical/mobility disability ☐ Dementia ☐ Learning disability ☐ Difficult seeing
☐ Difficult hearing, or having speech understood ☐ Another communication disability (specify):
☐ Another mental disability, not related to mental illness ☐ Another disability (specify):_____

Referring Program Information: (Provider/Program)
☐ One Step a la Vez ☐ Project Esperanza ☐ Tri-County GLAD ☐ Rainbow Umbrella ☐ COMPASS
☐ F&F ☐ PYPF ☐ EDIPP ☐ Eating Disorders ☐ Clinicas del Camino Real
☐ PEP ☐ F&F ☐ Promotoras(MICOP) ☐ Other: _____

Reason for referral to program above:

All Referrals

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

Date written referral was made: _____ Name of Program/Org. *RECEIVING* Referral: _____
Contact Name: _____ Address: _____
Contact #: Email:

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: _____

COUNTY Mental Health Referrals ONLY

Please complete ONLY for referrals to COUNTY Mental Health Treatment Programs NOT 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? ☐ No ☐ Yes
If yes, approximate and most recent date month/year: _____

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

Submit by Email

☐ Data entered in Avatar Pg.2