PLUMAS COUNTY BEHAVIORAL HEALTH SERVICES
270 County Hospital Road, #109 Quincy, CA 95971 (530) 283-6307 FAX (530) 283-6045

Sharon R. Sousa, LMFT, Director

PLUMAS COUNTY BEHAVIORAL HEALTH
CARE ACT OUTREACH REFERRAL
Please send via secure email to UM@pcbh.services

IF THIS IS A PSYCHATRIC EMERGENCY, PLEASE CALL 911
Medication or involuntary long-term hospitalization/conservatorship cannot be mandated as a part of CARE Act proceedings.
INSUFFICIENT DETAILS MAY DELAY THE REFERRAL PROCESS

Date of Referral: _____

INDVIDUAL SUBMITTING REFERRAL

Agency:_____Contact Name: _____

Phone:_____Email:_____

CARE ACT RSPONDENT

Last Name: _____First Name:_____ Gender: ☐Male ☐ Female ☐ Other

SSN:_____Date of Birth:_____☐Candidate served in the U.S Military

Address:_____City:_____Zip:_____
If Unknow, specify location last found at (e.g. corner of 1st/Main)

Phone:_____Preferred Language:_____

Race/Ethnicity: ☐White/Non-Hispanic ☐ Hispanic ☐ Native American/Alaskan ☐African American/Black

☐Asian ☐ Unknown ☐Multi-race ☐ Other:_____

CURRENT LIVING SITUATION:
☐Homeless/Unsheltered ☐ Homeless Shelter ☐ Hospital ☐Housing/Apt ☐ Jail/Correctional Facility
☐Sober Living ☐ Psychiatric Facility ☐ With Family/Adult ☐Unknown

INSURANCE: Check all that apply
☐Medi-CAL ☐ MediCARE ☐ Private ☐None ☐ unknown ☐ Other:_____

BENFITS: Check all that apply and list amounts. ☐None
☐ GA/GR $_____ ☐ VA $_____ ☐SSI $_____ ☐SSDI $_____ ☐Pending

☐Unknown ☐ Other:_____$_____

CONSERVRTOSHIP IN PLACE: ☐ Yes ☐ No
If Yes, Please list dates, phone numbers and names:_____

_____

SUPPORT SYSTEM (Family Friends, IHSS and other services)
If applicable, please provide contact information:_____
_____
_____
_____

SUBSTANCE USE: ☐Never Used ☐ Currently Using ☐ Past Use ☐ Unknown Age of 1st use_____

List Type(s) of substance used and frequency:_____

_____

Individual has received substance use treatment: ☐ Yes ☐ No

Treatment Program Name and estimated dates of services:_____

_____

PHYSICAL HEALTH CONDITIONS & MEDICATION(S):_____

_____

MENTAL HEALTH DIAGNOSIS(S):_____

Individual is prescribed Mental Health/Psychiatric Medication(s): ☐ Yes ☐ No

If yes; ☐ Takes medications as prescribed ☐ Sometimes takes medications ☐ Never takes medications

☐ Takes medications most of the time ☐ Rarely takes medications ☐ Refuses medications ☐ Unknown

☐ Other:_____

List Mental Health/Psychiatric Medication(s):_____

Is the individual currently receiving mental health services? ☐ Yes ☐ No

If yes, Agency:_____Phone:_____

Type of services receiving?_____

	List Dates of Admission and Discharge		Describe Reason For Admission
NO. of Arrests in the Past 36 Months:_____			
NO. of Psych Hospitalizations in the Past 36 Months:_____			

	List Dates	No. Of Times Police Have Been Called	Describe Act of Violence
NO. of Acts of Serious Violence Towards Self: _____			
NO. of Acts of Serious Violence Towards Others:_____			

Describe individual's **IMMEDIATE RISK & SAFETY CONCERNS** including danger to shelf and other, and how mental illness interferes with their primary activities of daily living:
Describe how the individual is **UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DETERIORATION** (e.g. unable to care for self or provide food, clothing, shelter, personal safety, and/or medical needs):
Describe the individual's **HISTORY OF NON-COMPLIANCE WITH TREATMENT** (has been offered the opportunity to participate in treatment and fails to engage)