PROJECT HOPE

Referral Form

Date of Referral: ☐ / ☐ / ☐

Does client have Medi-Cal: Yes: ☐ No: ☐ Medi-Cal #: ☐

(Project Hope will primarily serve adults with Medi-Cal with Mental Health benefits. **Private insurance will not be accepted by Alma Family Services.**)

Client complete referral packet is attached to Referral Form: Yes: ☐

Service Coordinator (S.C.) who made the referral: ☐

S.C. Phone #: - - S.C. Fax #: - -

S.C. Supervisor: ☐ Supervisor Phone #: - -

Client Information:

Client Name: ☐ UCI: ☐ S.S. # ☐

D.O.B: / / Age: ☐ Sex: Male ☐ Female: ☐

Client Address: ☐

Phone #: - - Alternate Phone #: - -

Primary Language: ☐ Communication: Verbal: ☐ Non-Verbal: ☐

Best day of the week/time to contact the client? Day: ☐ Time: ☐

(Call are made Monday -- Friday between the hours of 8:30 AM – 5:00 PM)

Is Client interested in participating in any of the following PROJECT HOPE services, if recommended? (Please check any that apply)

- ☐ Case Management
- ☐ Individual Psychotherapy
- ☐ Medication Management
- ☐ Group Social Skills Training
- ☐ Group Anger Management Training
- ☐ Group Sexuality Training

Client will require transportation arrangements to be able to attend services. What are the transportation options for this individual?

- ☐ Public Transportation
- ☐ Facility staff will transport. Who ☐ Phone #: - -
- ☐ Family member will transport. Who ☐ Phone #: - -
- ☐ Friend will transport. Who ☐ Phone #: - -

Client Living Arrangement:

Client lives at family home: Yes: ☐ No: ☐

If YES, provide name, relationship and contact information of person/people living with the client:

Client lives at a residential facility: Yes: ☐ No: ☐

If YES, provide Facility Name:

Facility Administrator Name:

Facility Phone #: - - Alternate Phone #: - -

Client lives in own apartment/independently: Yes: ☐ No: ☐

If YES, does client have an ILS/SLS provider?: Yes: ☐ No: ☐

If YES, provide agency name and contact information to ILS/SLS provider:

Other Relevant Information:

Is client conserved?: Yes: ☐ No: ☐ If yes, consent form should be signed appropriately.

If YES, provide name, phone # and relationship to client:

Does client have a family member or other individual who is involved in the care/decisions of the client?: Yes: ☐ No: ☐

If YES, provide name, address, phone # and relationship to client:

Provide any other information the PROJECT HOPE team may need to know about your client with regards to receiving services from PROJECT HOPE:

SG/PRC OFFICE USE ONLY: Reviewed by SG/PRC Project Manager:_____ Date:_____

Individual meets project criteria:

☐ 1 or more hospitalizations within last 5 years (confirmed via SIR, hospital discharge report or I.D. Note from Regional Center)

☐ 18 years of age and over

Referral:

☐ Complete Referral Form ☐ Complete Referral Packet ☐ Signed Consent Form

Funding Source: ☐ Medi-Cal Mental Health ☐ Other: Explain

Client #: with regards to PROJECT HOPE program capacity. Program capacity is 50.

☐ Other Comments:

ALMA FAMILY SERVICES OFFICE USE ONLY:

Reviewed by Alma Family Services Intake Department: _____ Date: _____

Date Service Coordinator was informed of outcome of intake process: _____ Phone Call ☐ or E-mail message ☐

C: SG/PRC Client File

PROJECT HOPE- This project and form are funded by the Mental Health Services Act (MHSA) in partnership with the California Department of Mental Health and Department of Developmental Services (DDS). PROJECT HOPE is a collaborative effort between Alma Family Services and San Gabriel/Pomona Regional Center (SG/PRC) to help increase one's quality of life.