

Bi-Directional Medi-Cal Mental Health Level of Care Transition Form

INSTRUCTIONS: Complete this form when transitioning a Medi-Cal client in active services between levels of mental health care. Please provide details on the type of transition requested and also provide the clinical information on page 2. Clinical information can be completed on the form <u>OR</u> with last two progress notes and medication log (if applicable). When transitioning to the Managed Care Plan (mild to moderate impairment) level of care, please fax the completed form to Beacon at **877-768-2306**.

THE RESERVE OF THE PERSON OF	Mambar Damagra	unblos	THE STATE OF STREET			
	Member Demogra	pnies				
Client Name:			/			
(Last) Client phone	Medi-Cal H	(First) ealth Plan				
Medi-Cal ID#	Language/Cultural Requ	virements				
Address:	City:	Zip:	Phone: ()			
			Phone: ()			
(Name)		(Relationship)				
TO THE RESERVE THE RESERVE	Transition Request L	Details	TON SHEET IN THE			
Reason for transition	340					
☐ TO BEACON: No longer meets medical nec	essity for Specialty MH Servic	ces (SMHS) (mild to mode	erate impairments due to MH Dx)			
☐ TO COUNTY: Meets medical necessity for Sp			·			
Other						
Member notified of transition for services:	Yes No					
Medication Management requested/ to be managed by:						
Primary Care Beacon contracted psychiatrist County SMHS Other N/A						
Therapy requested/to be managed by:						
☐ Beacon contracted therapist ☐ Coun	ty SMHS		_			
If member formerly saw Beacon provider, r	name/clinic of that provid	ler:	or			
Attached Documents (check any that apply): [summary Other		ress notes 🗌 Medico	ation Log 🔲 Discharge			
Consent to share PHI: Release of Inform	nation (ROI) attached [Verbal consent (do	ate received)			
	Sending Clinician	Info	SSTEEL PLANS			
Staff name:	T	itle/licensure:				
Date: Phone: ()	E	mail:				



Services provided to member while in SMHS or Beacon level services: Medication Management Psychological Testing Individual/Group Therapy TBS Case Management Wrap services Crisis Intervention Other Risk Factors: Psychiatric hospitalization within last year. If yes, date Active S/I or H/I with plan or intent. If yes, please describe below. Recent trauma/loss. If yes, please describe below. Recent release from prison system. If yes, please describe below.	Primary Diagnosis:	agnosis: Secondary Diagnosis:					
Services provided to member while in SMHS or Beacon level services: Medication Management	Admit Date:	Discha	rge Date:				
Services provided to member while in SMHS or Beacon level services: Medication Management	Medication		Dose	Last Change Date			
Services provided to member while in SMHS or Beacon level services: Medication Management							
Services provided to member while in SMHS or Beacon level services: Medication Management Psychological Testing Individual/Group Therapy TBS Case Management Wrap services Crisis Intervention Other Risk Factors: Psychiatric hospitalization within last year. If yes, date Active S/I or H/I with plan or intent. If yes, please describe below. Recent trauma/loss. If yes, please describe below. Recent release from prison system. If yes, please describe below. Increased psychosocial issues exacerbating MH condition. If yes, please describe below.				8			
Services provided to member while in SMHS or Beacon level services: Medication Management Psychological Testing Individual/Group Therapy TBS Case Management Wrap services Crisis Intervention Other Risk Factors: Psychiatric hospitalization within last year. If yes, date Active S/I or H/I with plan or intent. If yes, please describe below. Recent trauma/loss. If yes, please describe below. Recent release from prison system. If yes, please describe below. Increased psychosocial issues exacerbating MH condition. If yes, please describe below.							
Services provided to member while in SMHS or Beacon level services: Medication Management Psychological Testing Individual/Group Therapy TBS Case Management Wrap services Crisis Intervention Other Risk Factors:							
Services provided to member while in SMHS or Beacon level services: Medication Management							
Medication Management ☐ Psychological Testing ☐ Individual/Group Therapy ☐ TBS ☐ Case Management ☐ Wrap services ☐ Crisis Intervention ☐ Other							
□ TBS □ Case Management □ Wrap services □ Crisis Intervention □ Other	Services provided to member v	while in SMHS or Beacon level s	ervices:				
□ Crisis Intervention □ Other Risk Factors: □ Psychiatric hospitalization within last year. If yes, date □ Active S/I or H/I with plan or intent. If yes, please describe below. □ Recent trauma/loss. If yes, please describe below. □ Recent release from prison system. If yes, please describe below. □ Increased psychosocial issues exacerbating MH condition. If yes, please describe below.	Medication Management	Psychological Testing	☐ Individual/Group I	herapy			
Risk Factors: Psychiatric hospitalization within last year. If yes, date Active S/I or H/I with plan or intent. If yes, please describe below. Recent trauma/loss. If yes, please describe below. Recent release from prison system. If yes, please describe below. Increased psychosocial issues exacerbating MH condition. If yes, please describe below.	☐ TBS	Case Management	☐ Wrap services				
 □ Psychiatric hospitalization within last year. If yes, date □ Active S/I or H/I with plan or intent. If yes, please describe below. □ Recent trauma/loss. If yes, please describe below. □ Recent release from prison system. If yes, please describe below. □ Increased psychosocial issues exacerbating MH condition. If yes, please describe below. 	Crisis Intervention	Other					
 □ Active S/I or H/I with plan or intent. If yes, please describe below. □ Recent trauma/loss. If yes, please describe below. □ Recent release from prison system. If yes, please describe below. □ Increased psychosocial issues exacerbating MH condition. If yes, please describe below. 	Risk Factors:						
 ☐ Recent trauma/loss. If yes, please describe below. ☐ Recent release from prison system. If yes, please describe below. ☐ Increased psychosocial issues exacerbating MH condition. If yes, please describe below. 	Psychiatric hospitalization w	ithin last year. If yes, date					
Recent release from prison system. If yes, please describe below. Increased psychosocial issues exacerbating MH condition. If yes, please describe below.	☐ Active S/I or H/I with plan or	intent. If yes, please describe l	pelow.				
☐ Increased psychosocial issues exacerbating MH condition. If yes, please describe below.	Recent trauma/loss. If yes, p	olease describe below.					
	Recent release from prison s	system. If yes, please describe l	pelow.				
Relevant Clinical information:	☐ Increased psychosocial issue	es exacerbating MH condition.	If yes, please describe be	elow.			
	Relevant Clinical information:						
	W						
u		•					
si	1						