* MUST BE FILLED OUT AS COMPLETELY AS POSSIBLE

Revised 8/2/2018

S.A.F.E. MEETING REFERRAL FORM

Region (select one below):

☐ Atascadero S.A.F.E. PH: 466-5404 F: 462-8901 E: northcountysafe@linkslo.org
☐ Paso Robles S.A.F.E. PH: 238-2775 F:226-5437 E: northcountysafe@linkslo.org
☐ SLO S.A.F.E. PH: 781-4178 F:781-1265 E: tclarke@co.slo.ca.us
☐ South County S.A.F.E. PH: 474-2105 F: 474-2025 E: behavioralhealth.SAFE@co.slo.ca.us

S.A.F.E Office Use Only

Reviewed by:_____

Case Manager:_____

Referral Date:_____ Referred By:_____

Referring Agency:_____ Referral Phone #:_____ Fax#:_____

REQUESTED ATTENDANCE:

Name/Affiliation **(Besides SAFE Team members)**	Phone	Fax	Contacted
School Contact:			

Office use only: Pre-Staffing Meeting Start Time Location

Scheduled SAFE date/time:_____ date/time:_____ _____

☐Transportation Needed ☐ Translation Needed ☐Case previously presented: ☐No ☐Yes Date_____

CHILD'S NAME	AGE	ADDRESS	CITY/ZIP	PHONE	
SOC SEC#	GRADE	DOB	SCHOOL OF ATTENDANCE	Current Placement	Sex / Ethnicity*
MOTHER'S NAME	DOB	PHONE	Ethnicity*	Legal Guardian's Name (If different)	PHONE
Mothers Address (if different, include city/zip)				Relationship to child	
FATHER'S NAME	DOB	PHONE	Ethnicity*	Address (if different, include city/zip)	
Father's Address (if different, include city/zip)					

SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL	Others Living in the Home	DOB
SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL		
SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL		
SIBLING	Living in Same home	Yes/No	DOB	Sex	Ethnicity*	GRADE	SCHOOL		

CURRENT STATUS/OPEN CASES

Closed	Open	Staff	Case#
☐ DSS	☐	_____	_____
☐ CWS	☐	_____	_____
☐ Probation	☐	_____	_____
☐ Mental Health	☐	_____	_____
☐ Public Health	☐	_____	_____
☐ Spec. Ed.	☐	_____	_____
☐ D & A	☐	_____	_____
☐ Other	☐	_____	

FINANCIAL STATUS

☐ Medi-Cal ☐ CalWORKs (families)
☐ Insurance (private) ☐ AFDC-FC (foster child)
☐ Healthy Families ☐ Other_____

*ETHNICITY CODES

10 Native American	50 Hispanic
20 Asian	60 African American
30 Pacific Islander	70 White
40 Filipino	90 Other

Previous Placement (date):_____

Medical Concerns/Medication(s) (Note MD's Name):_____

Current Therapist/Psychiatrist:_____ _____
Name Phone Number

Student/Child/Family Strengths:

Presenting concerns/specific reasons for referral. Information on siblings is extremely helpful.

1. Presenting concerns/specific reasons for referral:

☐Substance Abuse	☐Employment Concerns
☐Parent Child Conflict	☐Child Behavioral Concerns
☐Loss/Grief	☐Educational Concerns
☐Homelessness	☐Criminal Behavior by parent
☐Domestic Violence	☐Criminal Behavior by youth
☐Financial Stress	☐Child Developmental Concerns
☐Child Abuse/Neglect	☐Bonding/Attachment Concerns
☐Medical Concerns	☐Other (List):
☐Mental Health Concerns	

2A. What would the referring party like to see happen at the meeting/purpose?

2B. What would the family like to see happen at the meeting?

3. How are attendance, siblings, behavior, etc.?

4. What current services/agencies is the family already connected to?

5. Does the family need immediate assistance from a family advocate? Are they Spanish speaking?

COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION

Date:	Last Name:	First Name:	Middle Initial:
Address:	City/State:		Zip Code:
Home Number: Cellular:	Ok to Leave Message: Choose	Language Choose:	Date of Birth:
Parent/Guardian:	Case Type: Choose:		Case Number:

AUTHORIZATION TO DISCLOSE AND EXCHANGE MY HEALTH CARE OR PERSONAL INFORMATION

I authorize the agencies initialed below to share my health care and personal information with each other. If I am signing as the guardian or representative for another person, I authorize the agencies that I have initialized below to share that person's health care and personal information with each other. I understand that this authorization is voluntary and that I do not have to sign it.

PLEASE INITIAL FOR EACH AGENCY AUTHORIZED TO EXCHANGE YOUR INFORMATION:

Note: The organizations listed below may only exchange information described in this document and may only exchange the information for the purposes described.

TREATMENT PROVIDERS – YOU DO NOT NEED AN INDIVIDUAL'S NAME TO SHARE HEALTH CARE AND PERSONAL INFORMATION (PHI) WITH TREATMENT PROVIDERS

Initial Here		Initial Here	
Initial Here	County of SLO Public Health Department	Initial Here	County of SLO Mental Health Services
Initial Here	CenCal Health	Initial Here	Transitions-Mental Health Association(T-MHA)
Initial Here	Community Health Centers (CHC)	Initial Here	Hospital: Choose:
Initial Here	County of SLO Drug and Alcohol Services (DAS)	Initial Here	Other:

NON-TREATMENT PROVIDERS – YOU MUST HAVE AN INDIVIDUAL'S NAME TO SHARE HEALTH CARE AND PERSONAL INFORMATION (PHI) FROM DRUG AND ALCOHOL PROGRAM

Initial Here			
Initial Here	County of SLO Probation Department	Names	
Initial Here	Dept. of Social Services: Choose:	Names	
Initial Here	CAPSLO: Choose:	Names	
Initial Here	Tri-Counties Regional Center (TCRC)	Names	
Initial Here	Foster Family Agency: Choose:	Names	
Initial Here	Department of Rehabilitation	Names	
Initial Here	Family Resource Centers: Choose:	Names	
Initial Here	Victim/Witness Program – County SLO D.A.	Names	
Initial Here	Veterans Services Department – County of SLO	Names	
Initial Here	SLO County Office of Education (SLOCOE)	Names	
Initial Here	Allan Hancock EOPS/CalWORKs	Names	
Initial Here	Cuesta College: Choose:	Names	
Initial Here	School District: Choose:	Names	
Initial Here	Stand Strong	Names	
Initial Here	HASLO (Housing Authority of SLO)	Names	
Initial Here	Homeless Services: Choose:	Names	
Initial Here	Independent Living Program (ILP)	Names	
Initial Here	RISE	Names	
Initial Here	Job Centers: Choose:	Names	
Initial Here	Other:	Names	
Initial Here	Other:	Names	

HEALTHCARE OR PERSONAL INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES

NOTE: THIS AUTHORIZATION FORM ALLOWS DISCLOSURE OF ALL YOUTH HEALTH AND SOCIAL SERVICES RECORDS UNLESS YOU SPECIFY A SPECIFIC LIMITATION.

The identified agencies can share any and all information from your health care records or personal records or from the health healthcare records or personal records of the person of the person for whom you are authorizing this disclosure, for the purposes listed below. The information may come from your San Luis Obispo County physical health records, mental health records, or drug and alcohol treatment records. The information may also come from your Social Services records or the records of any other agency you authorized to share your information. The information used, disclosed or shared may be written or oral, and will only include information necessary to achieve the intended purpose or referral.

Initial Here **Initial here to indicate you understand we will share your mental health information.**

Initial Here **Initial here to indicate you understand we will share your Drug and Alcohol Program Information.**

Describe the type and amount of Drug and Alcohol Program Information that can be disclosed:

- ☒ Drug and Alcohol Test Results
- ☒ Drug and Alcohol Treatment Plan
- ☒ Drug and Alcohol Payment Information
- ☒ Substance Use Diagnosis
- ☒ Drug and Alcohol Program Attendance
- ☒ Discussions with my Drug and Alcohol Counselor

PURPOSE AND LIMITATIONS ON THE USE OF YOUR HEALTHCARE OR PERSONAL INFORMATION

The information will be used by the identifed agencies to refer you to and request services from agencies that you authorized in this document. The information may also be used to coordinate care or to coordinate services between the agencies. These services may be in areas such as health care, housing, employment, education, nutrition, parenting, child welfare, and/or other traditional social services.

This authorization to release the above information will **expire two years from the date signed** or will expire on: _____ **(Not more than 2 years.)**

I understand that:

- I understand that I have a right to receive a copy of this authorization.
- I have the right to revoke this authorization verbally, or by sending a signed notice to:
  - County Privacy Officer: 2180 Johnson Ave., San Luis Obispo, CA, 93401
  - Or via e-mail at privacy@co.slo.ca.us ; or call (855) 326-9623
  - This authorization will cease on the date my valid revocation request is received. I also understand that any information released prior to a revocation of this authorization shall not be a breach of my confidentiality.
- A form known as The Notice of Privacy Practices which is given to clients who receive medical services, provides instructions should I chose to revoke my authorization and includes limitations on my revocation. I can access this notice on the internet at: http://www.slocounty.ca.gov/Departments/Health-Agency.aspx
- My treatment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
- Upon request, I may inspect or obtain a copy of the health information that I am allowed to be disclosed.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA); for example, if I allow disclosure to a family member.
- Records and copies obtained relating to outpatient psychotherapy shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.
- I understand that alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 and 164, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

Employee Name:	**Organization filling out this form:**	**Date:**
Client Signature:	**Print Name:**	**Date:**
Representative Signature:	**Relation:**	**Date:**

COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION

ADDITIONAL CONSENT FOR RECIPIENTS OF PROTECTED DRUG AND ALCOHOL TREATMENT INFORMATION TO SHARE THE INFORMATION WITH OTHERS

NOTE: This page is to be filled out if Drug and Alcohol Treatment information that was shared by the client's Drug and Alcohol Treatment provider is intended to be further disclosed (re-disclosed) by the initial recipients to another individual agency (such as the Superior Court, District Attorney, Probation, Department of Social Services). **If completed, this page must be attached to page 1 and 2 of this Authorization form.**

Full Client Name:		**Date of Birth:**	

I authorize the disclosure of my Drug and Alcohol Treatment information or the information for the person for whom I am signing, to be shared by the following individuals:

Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	

DRUG AND ALCOHOL TREATMENT INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES

Initial Here	
Initial Here	Any information related to your participation in the Drug and Alcohol Program including your status as a patient, date of admission, initial evaluation, assessment results/ history, attendance, date of discharge, discharge plan and discharge status.
Initial Here	Summary of your treatment plan, progress in the program, and compliance.
Initial Here	Any drug test results including urinalysis, breathalyzer/ patching test results.
Initial Here	Any personal information about your household, relationships and children including observations and evaluations of minors with whom you interact.

PURPOSES AND LIMITATIONS ON THE USE OF YOUR DRUG AND ALCOHOL SERVICES INFORMATION

The information described above may be used, disclosed and/or re-disclosed by and between the agencies listed above to assist them in handling your Department of Social Services case, your Family Court case, your Probation case, your court/criminal Justice case and/or any other matter related to this authorization.

I voluntarily sign this authorization to disclose my Drug and Alcohol Program information to the agencies listed above. I understand these agencies will share this information with each other.

Employee Name:	**Organization filling out this form:**	**Date:**
Client Signature:	**Print Name:**	**Date:**
Representative Signature:	**Relation:**	**Date:**