Transition of Care Tool for Medi-Cal Mental Health Services

The Transition of Care Tool for Medi-Cal Mental Health Services (hereafter referred to as the Transition of Care Tool) leverages existing clinical information to document an individual's mental health needs and facilitate a referral to the individual's Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) as needed. The Transition of Care Tool is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system or 2) services need to be added to their existing mental health treatment from the other delivery system.

Instructions: The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician in alignment with protocols. Once a clinician has made the determination to transition care or refer for services, all of the following actions must be taken:

1. Complete the Transition of Care Tool.
2. Send the Transition of Care Tool and any relevant supporting documentation to the plan the beneficiary is being referred to.
3. Continue to provide necessary mental health services and coordinate the transition of care or service referral with the receiving plan, including follow up to ensure services have been made available to the individual.

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION		
☐ County Mental Health Plan ☐ Managed Care Plan		
Submitting Plan:		
Plan Contact Name:	Title:	
Phone:	Email:	
Address:		
City:	State:	Zip:

BENEFICIARY INFORMATION		
Beneficiary's Name:		Date of Birth:
Beneficiary's Preferred Name:		
☐ Beneficiary or Legal Representative is in Agreement with Referral or Transition of Care	**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary ☐	
	Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐	
Address:		
City:	State:	Zip:
Phone:	Email:	
Caregiver/Guardian:	Phone:	
Medi-Cal Number (CIN)/SSN:		

BENEFICIARY INFORMATION

Behavioral Health Diagnosis or Diagnoses, if known:

Supporting Clinical Documents Included:

Cultural and Linguistic Requests:

Current Presenting Symptoms/Behaviors (including substance use if appropriate):

☐ Additional Pages Attached

BENEFICIARY INFORMATION

Current Environmental Factors (including changes in caregiver relationships, living environment, and/or educational considerations):

☐ Additional Pages Attached

Brief Behavioral Health History (including psychosocial stressors and/or traumatic experiences):

☐ Additional Pages Attached

Brief Medical History:

☐ Additional Pages Attached

Current Medications/Dosage:

☐ Additional Pages Attached

BENEFICIARY INFORMATION	
Referring Provider/Current Care Team:	Phone:
SERVICES REQUESTED: ☐ Transition of Care ☐ Addition of Service(s)	
What service(s) is the beneficiary being referred for?	
TRANSITION OF CARE OR SERVICE REFERRAL DESTINATION	
☐ Managed Care Plan:	
Managed Care Plan Contact Information	
Fax: Phone: Toll Free: TTY:	
☐ County Mental Health Plan:	
County Mental Health Plan Contact Information	
Fax: Phone: Toll Free: TTY:	

Clear Form