iCARE Mobile Engagement Referral Form

Note: This is not a resource connection, case management program for someone who is compliant with their treatment, however, if a referral is received, the screening process will identify appropriate resources and the referral may be re-routed to the appropriate program. Please be aware that this is not a crisis program. If a person is in crisis, please call the SYBH 24/7 access line at 530- 673-8255.

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1) **What does the iCARE Mobile Engagement Team do**?
    - The iCARE Mobile Engagement Team provides community (field-based) services in the form of outreach, engagement, family education and support for the most challenging, diverse, members in the community age 18 and older, who suffer from untreated mental illness, in an effort to invite the individual into the mental health system to receive appropriate services.
    - The iCare Mobile Engagement Team is **not** a resource connection or case management program for someone who is compliant with their treatment, however, if a referral is received, the screening process will identify appropriate resources and the referral may be re-routed to the appropriate program.
    - Please be aware that this is not a crisis program. If a person is in crisis, please call the SYBH 24/7 access line at 530- 673-8255.

2) **In order to be served by the iCare Mobile Engagement Team, the adult (age 18 and over) must meet at least one (1) of the following criteria:**
    - Does not follow through or refuses necessary outpatient treatment.
    - Often uses crisis services (911, police, crisis services, psychiatric hospitals and emergency departments) without outpatient treatment follow-up.
    - Has been cared for in private residences by families and loved ones without the assistance of needed effective behavioral health supports.

3) **How does someone make a referral**?
    A referral form has been created for the project and can be completed by anyone by emailing the completed the referral form to iCAREreferrals@co.sutter.ca.us.

4) **How does someone learn more about the iCARE program?**
    Call Telecare at (530)565-0960 for more information.

Telecare Office Use Only:

Client ID #: _____

Screened & Approved for Services by Clinic Supervisor: _____

Assigned to Team: _____ Date: _____

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Please complete this form with as much information as possible. "*" Indicates a required field.

*Date referral completed: _____ *Completed By: _____

*Referral Source: ☐ AHRO (Hospital) ☐Law Enforcement ☐ Telecare ☐Family ☐ PES ☐PHF
☐ SYBH Outpatient ☐ Other:_____

*Name of person making referral: _____

*Referring Individual's Phone #: _____ *Relationship to referred individual:_____

Referred Individual's Information

*Legal Name:_____Preferred Name:_____

Date of Birth (DOB): _____ Age:_____ Social Security #:_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Unknown

Veteran Status, if known: _____

Race/Ethnicity: ☐American Indian/Alaskan Native ☐ Asian ☐ African American/Black
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Latino/Hispanic ☐ More than one race
☐ Declined to answer ☐ other (specify)

*Preferred Language: ☐ English ☐ Spanish ☐ other (please specify)_____

*Individual's Address: _____

*Individual's Phone #: _____

Health Insurance, if known:_____

Existing Client Medical Record #: _____

*Reason for Referral:

_____
_____
_____