CalWORKs

CLINICAL ASSESSMENT PROVIDER REFERRAL

[(Participant's Name and Address)] [(GAIN Regional/REP Office)]

[(GSW/CCM/RCM Name/File Number) ________________] [(Participant Case Number)____________________]

IMPORTANT CLINICAL ASSESSMENT APPOINTMENT NOTICE

Completed by GSW/CCM/RCM:

The following appointment has been scheduled for you to attend a clinical assessment for:

☐ Mental Health ☐ Substance Abuse

On:____/____/____ at__________
Date Time

Address: ______________________________
____

Phone No.: ______________________________

Fax No.: ______________________________

Contact Person: ______________________________

It is important for you to keep this appointment and take this notice with you.

If for any reason you cannot keep this appointment or have a problem, please contact your GAIN Services Worker immediately.

GSW/CCM/RCM Making Referral:	File No.:	Phone No.: ( )	Fax No.: ( )

I understand that I am being referred to Clinical Assessment as indicated above. If I fail to attend this appointment, I understand I may be subject to additional contact by a service provider. If additional contact is unsuccessful, I may be put into non-compliance.

______________________________ ______________________________
GAIN Participant's Signature Date

GN 6006A (Rev. 04/10)

CalWORKs CLINICAL ASSESSMENT RESULTS

[To: (GAIN Regional/REP Office)] [From: (Name & Address of Facility)]

Attention:________________________________
GSW/CCM/RCM Name/File Number

Fax No.: ________________________________
[ ] [ ]

Section A - Completed by GSW/CCM/RCM

Participant Name:			CalWORKs Case Number:
Residence Address: (Do not use for domestic violence if confidential address is requested.)			Mailing Address:
Primary Language:	Birth Date:	Sex: ☐ M ☐ F	Phone No.: (Confidential for DV) ( )

Section B - Completed by Clinical Assessor (Complete and return to the GAIN Services Worker within 5 workdays.)

Results of the assessment appointment:

IMMEDIATE NEED ☐

- ☐ Participant did not appear/complete the assessment.
- ☐ Participant completed the assessment, but does not need a referral for treatment.
- ☐ Participant completed assessment & needs a referral, but does not agree to treatment for ☐ MH ☐ SA
- ☐ Participant completed assessment and agrees to recommended treatment for ☐ MH ☐ SA
- ☐ Participant completed assessment and does not agree; requests third party assessment. ☐ MH ☐ SA

REFERRAL MADE FOR: ☐ MH and/or ☐ SA

Referred to:

Name of Provider: ________________________________

On: ____/____/_____ at ______________
Date Time

Address: ________________________________

____

Phone No.: ________________________________

Fax No.: ________________________________

Contact Person: ________________________________

Name of Assessor:	Facility Name:	Phone No.: ( )

Section C - Completed by GAIN Participant

I authorize the release of information to DPSS regarding the results of my assessment and possible need for treatment services and recommended service plan.

________________________________ ________________
GAIN Participant's Signature Date