Center on Juvenile and Criminal Justice

424 Guerrero Street, Suite A
San Francisco, CA 94110
415 621-5661
415 621-5466 fax
www.cjcj.org

Cameo House Referral Form

Referral Date:_____

Name of person submitting: _____Phone: _____
Organization_____Email:_____

Is the client on Probation?_____TX date_____ P.O. name?_____

Phone_____Email_____

Client Information

Name: _____ SF Jail # _____ CJ Pod _____

DOB: _____ Age: _____ Ethnicity:_____

Current Charges: _____ Next Court Date: _____

Legal Rep:_____Phone:_____ Email:_____

Client Children Information

Children's Names:	DOB:	Sex:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there an open CPS case?_____Worker name/contact_____

Child caretaker if other than mother_____

Children Current Address:_____Phone:_____

Mental Health, Financial, and Housing Status

Does the Client have **ANY** Mental Health: Yes No

If Yes, please list Diagnosis:_____

Is the Client on **ANY** Medication: Yes No

If Yes, please list Medication:_____

Is the Client in Therapy: Yes No

If Yes, please list Name/Organization, Phone and Email:

_____

Is the client currently employed?_____If so, where?_____

Is client receiving: GA_____CalWORKs_____SSI_____Unemployment_____SNAP_____Other?_____

Does the client have permanent housing in their name? Yes No

If Yes, what is the address:_____

If you answered no to housing question, please complete the attached Homelessness Questionnaire. If the answer is yes, this client is not eligible for Cameo House services.

Please email or fax the following forms to: rjackson@cjcj.org or 415-621-5664

- Completed Referral Form
- Release of Information Form
- Homelessness Questionnaire

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. **Failure to provide all information marked with an asterisk (*) may invalidate this authorization.**

Name of Client*:_____ **Date of Birth***:_____

I **authorize*** **Center on Juvenile and Criminal Justice Cameo House_** to disclose health information

(Name, title, & address of person or organization)*****

obtained in the course of my diagnosis and treatment for the **purpose of**:*****_____ and shall be limited to the following types of information – I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law requires that recipients refrain from re-disclosing such information except with my written authorization or as specifically required by law.

Discharge Summary # Results of Lab Tests # Assessment # Results of Psychological or Vocational Testing # Treatment Plan of Care # Educational Assessment and Behavioral Reports # Physician's Orders (including school observation & educational testing) # Progress Notes # Substance Use Treatment/Services # Other

(Specify)_____

Send to*:_____

(Name, title, & address of person or organization authorized to *receive* the information)

My Rights: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to CBHS or other facility. My revocation will be effective upon receipt, but will not be effective to the extent that CBHS may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this authorization. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

Expiration*: This authorization will automatically expire in 365 days from the date of execution unless a different end date or event is specified:*****_____ *** or immediately upon fulfillment of treatment.**

(date/event)

_____ **Date Signature_____**

Signature (Client/Patient/Parent/Guardian/Conservator) Relationship if not Client/Patient

_____ o Interpreter used _____

Witness (Required if Client/Patient unable to sign)

Notes: * A separate authorization is required to authorize the disclosure or use of **psychotherapy notes**. If this authorization is for the disclosure of **substance abuse** information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

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Homelessness Documentation

Client Name:_____

I. Type of documentation obtained:

____ Third Party Documentation

____ Staff Observation

____ **Client Self Certification (with certification form)

II. Description of the documentation Obtained:

_____
_____
_____
_____
_____
_____
_____
_____

III. **If Self Certification is being used, explain the process or attempts made to get third party verification first:

_____
_____
_____
_____
_____
_____
_____

☐ **Check here if all documentation is in case file**

Agency Staff Signature_____ Date _____