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Mental Health Services
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Home Start

Mental Health Referral Form

Date of Referral:	**Primary Client's Name (Child's name in most cases):**
Primary Caregiver (If different from Client):	**Client's Date of Birth:**
Street Address	Referrer's Name and Organization
City Zip	Address
Phone #1	City Zip
Phone #2	Phone # Fax #
Family's preferred language: / **Family's Ethnicity:**	**When is client available for sessions, give multiple time/days:**

Referral comments:

Has client experienced any of the following:

Physical Abuse
Sexual Abuse
Emotional Abuse
Neglect
Witness to DV
Bullying
Child Abduction
Victim of a Crime
Parental Substance Abuse
Child Maltreatment in Community

IMPORTANT:
Please FAX to Angela Stark at 619-692-0785.
Do NOT email due to confidentiality (HIPPA) laws.

CONSENT FOR REFERRAL: (circle answers)
As the referring party, I have received verbal consent from the primary caregiver and/or client to make this referral to Home Start, Inc. Yes No

Additionally, the caregiver and/or client has provided verbal consent to allow Home Start to make referrals to Healthy Development Services for children aged 0-5 years old.
Yes No

Does client have Medi-Cal or Private Insurance? Yes No

Has the client sought treatment through their insurance provider? Yes No

Reason for seeking treatment through Home Start rather through insurance:

- Long Waitlist
- Unable to afford co-pay
- No provider in their area
- Bad experiences w/services through insurance provider

Other:____
____