

CONFIDENTIAL

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ACCESS PROGRAM

1-800-491-9099

Primary Care Referrals for Specialty Mental Health Services

Facsimile Transmittal Sheet

Date: _____

To: ACCESS

Fax #: 510-346-1083

From: _____

Fax #: _____

Phone #: _____

Client Name: _____ Date of Birth _____

Parent/Guardian Name (if applicable): _____

Additional Information: _____

I have discussed this referral with my patient/client and directed him/her to call ACCESS next day to complete referral. **Completed Screening Form is attached.**

ACCESS to Complete:

CLIENT HAS NOT CONTACTED ACCESS TO COMPLETE THE REFERRAL PROCESS

REFERRED TO:

Provider Name or Managed Care Plan: _____

Phone#: _____ Fax #: _____

Provider Name: _____

Phone#: _____ Fax #: _____

The information contained in this fax is confidential under the California Penal Code. It is intended *only* for the use of the individual to whom it is addressed. If you are not the intended recipient, or the employee or agent responsible for delivery to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this fax in error, please immediately notify the sender by telephone.

ACCESS REFERRAL PROCEDURE FOR PRIMARY CARE PROVIDERS

Physicians/Behavioral Health Specialists:

1. Licensed provider to complete 'Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary' for appropriate age group. Please be sure to indicate how mental health symptoms are impacting your client's daily functioning. Note: non-licensed staff can complete the 'Member Info' section.
2. If client does not meet criteria for 'County Mental Health Plan' per the algorithm on the Screening Form, please refer to their Managed Care Plan (Kaiser, Anthem Blue Cross, or Beacon for Alameda Alliance). If you are unsure as to where client should be referred, follow this procedure and ACCESS will make the determination.
3. Complete ACCESS Program Fax Cover Sheet up to "ACCESS to Complete".
4. Fax completed Screening Form and ACCESS Program Fax Cover Sheet to ACCESS at 510-346-1083.
5. Direct client to call ACCESS (1-800-491-9099) the following business day to speak with an ACCESS clinician and complete the referral process.
6. If client doesn't contact ACCESS within 3 business days of referral request, ACCESS will fax back cover sheet to referring provider with box checked to inform you client has not yet contacted ACCESS. Please remind client to call ACCESS to complete the referral process.
7. Indicate on the fax cover sheet (under additional information) if you're concerned your client will not call ACCESS and would like ACCESS staff to reach out.

ACCESS:

1. Complete referral process after speaking with client.
2. Contact client with referral contact information (generally within 1-3 business days).
3. Complete bottom portion of fax cover sheet (referral information) and fax back to referring physician/clinician.
4. Include physician/clinician's name and phone number in the referral letter to the specialty mental health provider(s) with request that they collaborate with referring provider.
5. If client doesn't contact ACCESS within 3 business days of referral request, ACCESS will fax back cover sheet to referring provider to inform you that your client has not yet contacted ACCESS.