Solano County Behavioral Health

AB 1299 Presumptive Transfer
Medical Record Notice

Presumptive Transfer Intake Information

This confidential information is provided to you in accordance with State and Federal laws and regulations including, but not limited to, applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

Print Form

Client Name: _____

DOB: _____ Client Avatar #: _____

Client's Preferred Language: _____ Caregiver's Preferred Language: _____

Date Presumptive Transfer Referral Received: _____

Placing Agency: ☐ Child Welfare ☐ Probation County of Jurisdiction: _____

Person/Agency Authorized to Sign Consent for Treatment & CSP:

Name: _____

Relationship to Client: _____

Phone Number(s): _____

Street Address: _____

City, State, Zip Code: _____

Email: _____

Person/Agency Authorized to Sign Releases of Information:

☐ Same as Consent for Treatment above, or:

Name: _____

Relationship to Client: _____

Phone Number(s): _____

Street Address: _____

City, State, Zip Code: _____

Email: _____

Does the client have a current (within 1 year) assessment from another county? ○ Yes ○ No

Does the client have a treatment plan from another county that Solano County can provide services under for the first 60 days? ○ Yes ○ No

Does the assigned PSC need to complete and submit a *Request for Child & Family Team Meeting*, per the placing agency's request for ICC services from Solano County? ○ Yes ○ No ○ TBD

Above Information is Current As of Date: _____ Completed By: _____