# LAHSA/DHS/DMH REFERRAL FORM FOR BRIDGE/INTERIM HOUSING PROGRAM

Client Name: _____

Client Date of Birth: _____

**REFERRING PROGRAM UNIT/TYPE:** ☐

**DATE REFERRAL RECEIVED:** _____

## REFERRING AGENCY INFORMATION

Date of Referral: _____ Name of Referring Agency/Program: _____

Referring Staff Contact Name: _____ Referring Staff Title: _____

Referring Staff Contact Number: _____ Referring Staff Email Address: _____

Alternate Referring Staff Contact Name: _____ Alternate Referring Staff Title: _____

Alternate Contact Number: _____ Alternate Contact Email Address: _____

**REFERRING FACILITY*: Please choose ONE OPTION that best describes your facility/agency/program.**

***If you are unsure which option is most appropriate and your supervisor is not sure, please contact the appropriate agency as described on the fourth page of this application.***

☐ Private Hospital ☐ Private Non-DHS Urgent Care ☐ Jail/Custody Setting (Non-ODR) ☐ Mental Health Residential Treatment

☐ Skilled Nursing Facility ☐ CBEST ☐ Mental Health Outpatient Treatment

☐ Residential Substance Use Disorder Treatment Facility

☐ Substance Use Disorder Outpatient Treatment (including Withdrawal Management Program)

☐ Street-Based Outreach Worker: ***If selecting this option please select your SPA/Team information from the table below.***

☐ Other, please describe: _____

☐ OR Referring agency is a DHS ICMS provider AND this client does NOT fit into one of the above categories.

* If you are making a referral for DHS Interim Housing and are a Los Angeles County DHS (LAC DHS) hospital, facility, DHS ICMS, or ODR provider you should NOT make referrals using this application. Please use the full, online CHAMP application. Please note DMH and LAHSA do not use the CHAMP system.

**Street-Based Outreach SPA/Team Selection:** ☐ LAHSA Outreach Team ☐ DMH Outreach Team ☐ DHS Outreach Teams

*Please select your SPA/Team from the list below or complete the Other selection and include information on the outreach team.*

| | | |
|---|---|---|
| ☐ SPA 1 - MHA LA | ☐ SPA 4 - C3 Skid Row Team (Blue) | ☐ SPA 5 – St. Joseph's Center |
| ☐ SPA 1 - LAFH | ☐ SPA 4 - The People Concern | ☐ SPA 6 - HOPICS |
| ☐ SPA 2 - LAFH | ☐ SPA 4 - The Center at Blessed Sacrament | ☐ SPA 6 - SSG MLK Campus |
| ☐ SPA 2 - SFVCMC | ☐ SPA 4 - Homeless Health Care LA | ☐ SPA 6 - SSG CD8 |
| ☐ SPA 3 - USHS | ☐ SPA 4 - Exodus Recovery NELA | ☐ SPA 7 - PATH |
| ☐ SPA 4 - C3 Skid Row Team (Red) | ☐ SPA 4 - Exodus/LAC + USC Team | ☐ SPA 8 - MHA LA |
| ☐ SPA 4 - C3 Skid Row Team (Purple) | ☐ SPA 5 - C3 Venice Team | ☐ SPA 8 - Harbor UCLA Campus Team |
| ☐ SPA 4 - C3 Skid Row Team (Yellow) | ☐ SPA 5 – C3 Santa Monica Team | ☐ PATH Metro Redline Team |

☐ Other: _____

## REFERRING CLIENT INFORMATION

Client's Name (First, Middle, Last): _____ HMIS # (if known): _____ CHAMP ID # (if known): _____

DOB: _____ Age: ____ CES Acuity Score: ____ Score is for a: ☐ Youth/Adult ☐ Family Matched to Housing? ☐ Yes ☐ No

Primary Language: _____ Gender: ☐ Male ☐ Female ☐ Trans Man ☐ Trans Woman ☐ Other: _____

Pronoun Preference: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____

Client's Mobile Number: _____ Client's Email Address: _____

Client's Current Location: ☐ SPA 1 – Antelope Valley ☐ SPA 2 – San Fernando Valley ☐ SPA 3 – San Gabriel Valley ☐ SPA 4 - Metro LA ☐ SPA 5 – West LA ☐ SPA 6 – South LA ☐ SPA 7 – South East LA ☐ SPA 8 – South Bay/Long Beach

**MOBILITY LIMITATIONS (Check all that apply to any household member)**

☐ No Impairments ☐ Cannot climb stairs ☐ Uses walker/cane/crutches ☐ Uses motorized wheelchair
☐ Uses manual wheelchair ☐ Cannot transfer (e.g., from wheelchair to bed) ☐ Requires a bottom bunk ☐ Other: _____

| ADDITIONAL ASSISTANCE (Check all that apply) | | |
|---|---|---|
| ☐ Incontinence Issues (unable to self-care) | ☐ Respiratory (Supplemental Oxygen) | ☐ Reminders to take medications |
| ☐ Activities of Daily Living (Needs assistance with eating, grooming, and restroom use.) | | ☐ Sensory impairment/disability (Visual/Auditory) |
| ☐ Limited English proficiency requiring the use of translation services | Language requesting assistance with: _____ | |
| ☐ Independent with self-care/No assistance needed | ☐ Other: _____ | |

| **ASSISTANCE ANIMAL(S) (ONLY complete below if the client has an animal that will accompany them into Interim Housing.)** | | | |
|---|---|---|---|
| 1. Is the animal a service animal(s)? | ☐ Yes ☐ No | If yes, # of animal(s): ____ | Type(s): _____ |
| 2. Is the animal an emotional support animal(s)? | ☐ Yes ☐ No | If yes, # of animal(s): ____ | Type(s): _____ |
| 3. Is the animal a pet? | ☐ Yes ☐ No | If yes, # of animal(s): ____ | Type(s): _____ |

**ONLY COMPLETE SECTION BELOW IF HOUSEHOLD IS A FAMILY**

| Household Size: ___ | Number of Adults who identify as male: ___ Number of Adults who identify as female: ___ | Number of Minors in legal custody: ___ |
|---|---|---|

Number of Qualified Dependents (Over the age of 18 and incapable of employment due to mental or physical disability and dependent upon the head of household for support and maintenance): ____

Is the client pregnant? ☐ Yes ☐ No  Any other member of the household pregnant? ☐ Yes ☐ No

If pregnant, how many weeks? _____  If yes, relationship to client: _____

Any adult children/family to be housed with client? ☐ Yes ☐ No

Adult/Child #1 – Name: _____ Date of Birth: _____ Gender: _____

Adult/Child #2 – Name: _____ Date of Birth: _____ Gender: _____

Adult/Child #3 – Name: _____ Date of Birth: _____ Gender: _____

***If there are more individuals to be housed with the client, please provide the above requested information in the 'Additional Information' section below.***

**Additional Information:** _____

_____

**HOMELESS STATUS**

*Please select from the below what category best describes the client's or household's current living situation.*

☐ **HUD Category 1: Literally homeless**

- ☐ Sleeping in a place not meant for human habitation (i.e. street, park, campground, vehicle)
- ☐ Emergency shelter
- ☐ Transitional housing
- ☐ Residing in a hotel/motel paid for by a non- profit/charitable organization
- ☐ Exiting an institution (Jail or Prison, Foster Care, Medical or Substance Abuse Treatment facility) where the participant has resided for 90-days or less AND the participant resided in an emergency shelter or place not meant for human habitation before entering the facility.)

☐ **HUD Category 4: Fleeing/attempting to flee domestic violence *(Fleeing domestic violence, human trafficking, or sex trafficking)***

☐ Other Homeless (Please explain): _____

_____

**POST-INCARCERATION STATUS**

Is the client on: ☐ Probation ☐ AB 109 Probation ☐ Parole ☐ Non-Revocable Parole ☐ N/A

(Non-Revocable Parole refers to an individual who is not required to report to a parole agent)

## BRIDGE/INTERIM HOUSING PLACEMENT LOCATION

1. Willing to reside in a communal living environment*: ☐ Yes ☐ No
2. Willing to reside in the Skid Row area: ☐ Yes ☐ No

***Please note: most Interim Housing sites are communal living environments***

3. Any SPA(s) applicant CANNOT live in bridge/interim housing: Please check below

☐ SPA 1 – Antelope Valley ☐ SPA 2 – San Fernando Valley ☐ SPA 3 – San Gabriel Valley ☐ SPA 4 - Metro LA
☐ SPA 5 – West LA ☐ SPA 6 – South LA ☐ SPA 7 – South East LA ☐ SPA 8 – South Bay

**For DMH Interim Housing applicants, please answer the following questions:**

1. Does client have an Interim Housing provider preference? ☐ Yes ☐ No If yes, please specify: _____
2. Is client willing to go to alternate provider: ☐ Yes ☐ No

## MEDICAL INFORMATION

**Mark the corresponding box(es) below: *(Choose all that apply)***

*If medical is the client's primary issue, please provide additional details on the DHS Supplemental form (Attachment A) for any areas marked below.

☐ Medical conditions ☐ Mental Health issues ☐ Recent Substance Use ☐ Cognitive Impairments ☐ Other Challenges/Issues

☐ Client has none of the above referenced issues

**Information that may help match this individual to an appropriate bridge/interim housing placement:**

_____

_____

**If there is an urgent issue needing immediate attention, please describe:**

_____

_____

## TUBERCULOSIS (TB) SCREENING

1. Has the client had a cough recently that has lasted longer than 3 weeks? ☐ Yes ☐ No ☐ Don't Know
2. Has the client recently lost weight without explanation during the past month? ☐ Yes ☐ No ☐ Don't Know
3. Has the client had frequent night sweats during the past month, soaking your sheets or clothing? ☐ Yes ☐ No ☐ Don't Know
4. Has the client coughed up blood in the past month? ☐ Yes ☐ No ☐ Don't Know
5. Has the client been feeling much more tired than usual over the past month? ☐ Yes ☐ No ☐ Don't Know
6. Has the client had fevers almost daily for more than one week? ☐ Yes ☐ No ☐ Don't Know

***If client has a prolonged cough (> 3 weeks) plus any other TB symptoms, client must be promptly referred to an appropriate health care provider for an evaluation.***

TB Test Performed: ☐ Yes ☐ No Date Completed: _____ Results: _____

Chest X-Ray Performed: ☐ Yes ☐ No Date Completed: _____ Results: _____

## AUTHORIZATION FORMS

1. Do you have signed Authorization Forms? ☐ Yes ☐ No
2. Are the Authorization Forms Attached? ☐ Yes ☐ No

**REFERRAL SUBMISSION INSTRUCTIONS*: (*please check one of the below choices)***

☐ **IF CLIENT'S PRIMARY PRESENTING ISSUE IS MEDICAL**:

Submit the completed ***LAHSA/DHS/DMH referral form for Bridge/Interim Housing*** and the ***Supplemental Form for DHS Interim Housing Program (Attachment A)***, the signed ***DHS Housing For Health and/or DMH Authorization for Use and Disclosure of Protected Health Information Form*** and if applicable, the ***additional supporting documentation*** as described in the ***Admission Guidelines and Referral Process for DHS/DMH Interim Housing Program*** to the designated contact at **DHS** to request placement.

DHS - Ronnie Thomas or Rasheena Buchanan
Email: InterimHousing@dhs.lacounty.gov
Fax: (213) 895-6235

** If you are a Los Angeles County DHS (LAC DHS) hospital, facility, or DHS ICMS or ODR provider you should NOT make referrals using this application. Please use the full, online CHAMP application process to submit an application for DHS interim housing.*

☐ **IF CLIENT'S PRIMARY PRESENTING ISSUE IS A MENTAL HEALTH ISSUE**:

Submit the completed ***LAHSA/DHS/DMH referral form for Bridge/Interim Housing*** and the signed ***Authorization for Use and Disclosure of Protected Health Information Form*** and if applicable, the *additional supporting documentation* as described in the ***Admission Guidelines and Referral Process for DHS/DMH Interim Housing Program*** to the designated contact at **DMH** to request placement.

- Email: IHP@dmh.lacounty.gov

☐ **IF CLIENT'S PRIMARY PRESENTING ISSUE IS SUBSTANCE USE AND THE CLIENT IS INTERESTED IN SUBSTANCE USE TREATMENT**:

Refer client to Substance Abuse Prevention and Control (**SAPC)** to request access to substance use treatment, including outpatient and residential services.

- SAPC – Substance Abuse Service Hotline (SASH)
  Phone: (844) 804-7500

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☐ **IF CLIENT HAS NONE OR FEW OF THE ABOVE REFERENCED ISSUES** or doesn't need shelter services that provides health and/or mental health support, submit the completed ***LAHSA/DHS/DMH referral form for Bridge/Interim Housing*** to the designated contact at **LAHSA** to request placement.

- LAHSA – Andrew Hill, Sofia Peralta, Raquel Ziegler
  Email: interimhousing@lahsa.org

***PLEASE NOTE: If accepted to an Interim Housing placement, the referring agency must make appropriate transportation arrangements to the interim housing facility.**

**FOR LAHSA/DHS/DMH HOUSING STAFF ONLY**

Reviewed by: _____ Dept.: ☐ LAHSA ☐ DHS ☐ DMH ☐ DPH Date: _____ Client ID: _____

Approved: ☐ Yes ☐ No ☐ Pending Further Information: Describe:_____

If approved, referred to: _____

Type of placement facility: ☐ LAHSA Bridge Housing ☐ LAHSA Crisis Housing ☐ DHS Stabilization Housing ☐ DHS Med RC ☐ DHS Psych/BH RC ☐ DMH IHP ☐ DPH Substance Use Disorder Treatment Facility ☐ Other:_____

Other Placement Facility:_____

Placed on Waitlist: ☐ Yes ☐ No If yes, date: _____

If denied, reason(s): _____

Responsible staff: _____ Dept.: ☐ LAHSA ☐ DHS ☐ DMH ☐ DPH Referral Date: _____

Notes:_____