WELLNESS • RECOVERY • RESILIENCE

County of Los Angeles – Department of Mental Health

Mental Health Services Act (MHSA)

Full Service Partnership (FSP) Guidelines

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Countywide Programs Administration

- Children
- Transition-age Youth
- Adults
- Older Adults

Jonathan E. Sherin, M.D., Ph.D.,
Director

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

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OUTREACH AND ENGAGEMENT FOR CLIENTS IN INSTITUTIONS	**I.A.**	**11/1/2006** REVISION DATE **7/1/2017**	**1 of 4**

PURPOSE: To inform agencies with the following intensive services programs, Full Service Partnership (FSP) including Assisted Outpatient Treatment (AOT), Intensive Field Capable Clinical Services (IFCCS), and Wraparound, of the outreach and engagement expectations for referrals of clients residing in institutions.

DEFINITION:

1. Outreach and engagement are services provided to potential FSP clients prior to enrollment in a FSP program. Outreach and engagement services are used to build a relationship between the FSP program and potential client and to determine if the potential client is appropriate for FSP services.

    a. Outreach is defined as the initial step in connecting, or reconnecting, an individual or family to needed mental health services. Outreach is primarily directed toward individuals and families who might not use services due to lack of awareness or active avoidance, and who would otherwise be ignored or underserved. Outreach is a process rather than an outcome, with a focus on establishing rapport and a goal of eventually engaging people in the services they need and will accept.

    b. Engagement is defined as the process by which a trusting relationship between a service provider and an individual or family is established. This provides a context for assessing needs, defining service goals and agreeing on a plan for delivering the services. The engagement period can be lengthy and depends on the unique individual needs of consumer.

2. Institution includes county or fee-for-service (FFS) acute hospitals; Institutions for Mental Disease (IMD); Enriched Residential/IMD Step Downs; Skilled Nursing Facilities (SNF); State Hospitals (SH); Psychiatric Health Facilities (PHF); Jail; Juvenile Hall; Probation camps; Department of Juvenile Justice (DOJJ); and Short Term Residential Treatment Program (STRTP).

GUIDELINES: Clients referred to an agency while residing in an institution must be provided with outreach and engagement services prior to discharge and enrollment in an intensive services program.

1. Upon receiving a referral for a client in an in-patient hospital,

PHF, emergency room or urgent care center, agency staff shall conduct a face-to-face assessment within twenty-four (24) hours of receiving the referral to determine eligibility. For clients in all other institutional settings, agency staff shall conduct a face-to-face assessment within seventy-two (72) hours of receiving the referral to determine eligibility (see II. Eligibility Criteria)

2. Once eligibility is determined, the agency will begin outreach and engagement services, which include:

    - Regular Client Contact – The agency staff must maintain regular contact with the client and, if a minor, his/her parent/guardian. Regular client/family contact is a weekly phone call or personal visit, at minimum.

    - Contact With Institutions – In order to ensure continuity of care, the agency staff must maintain regular contact with those responsible for overseeing the client's care while in the institution. Regular contact is a weekly phone call or personal visit, at minimum.

        - For minor clients residing in Probation camps, the designated contact staff will generally be the DMH TAY System Navigators deployed in the Probation camps and responsible for linkage to aftercare resources.

        - For minor clients who are court dependents or wards, this also includes regular contact with responsible individuals from other county departments, such as Children and Family Services (Children's Social Worker), and/or Probation (Deputy Probation Officer) if applicable.

    - Discharge Planning – The agency staff shall share responsibility with the institution treatment staff to plan and coordinate discharge, including:

        - Agency staff taking primary responsibility for locating residential placement/housing based on the working relationships the agency has established with residential placement/housing

providers and the client's individual circumstances. Institution staff may assist with this responsibility as specified in the individualized discharge plan.

- Determining whether the agency or the institution will be responsible for transportation to the pre-arranged residential placement/housing; and

  Assuring the client has an adequate medication supply or prescriptions upon discharge.* The client typically receives a medication supply ranging from three days to 30 days or prescriptions, based on the point in the month the client is discharged and the amount of medications remaining. It is the responsibility of the institution staff to advise the agency of the medication supply and/or prescriptions the client will be provided on discharge and the responsibility of the agency to ensure the client has timely follow-up with the agency psychiatrist to ensure medication continuity. These activities should be done in collaboration with DMH liaisons, conservators and families.

- For clients residing in IMD's, the FSP agency staff shall be responsible for locating residential placement/housing and for transporting the client from the institution to their pre-arranged residential placement/housing.

3. Upon discharge from the institution, the agency may begin the enrollment process. If the conservator/client agrees to services, a Full Service Partnership Referral and Authorization Form must be submitted (see III. Referral, Authorization and Enrollment). The enrollment date must be effective after the client is released from the institution.

4. Active outreach and engagement lasting longer than 45 days requires consultation with impact unit and appropriate Countywide Program Administration.

5. Claiming for outreach and engagement services must be done through Community Outreach Services (COS). Outreach and engagement services typically fall under the COS category of "Community Client Services" (refer to DMH *Community Outreach Services Manual* for service definitions, codes and claiming instructions).

FORMS:

- Full Service Partnership Referral and Authorization Form
- Community Outreach Services claim form

REFERENCES

- Community Outreach Services Manual: http://file.lacounty.gov/SDSInter/dmh/159836_COS122010.pdf
- COS Claiming Tutorial on IS: http://lacdmh.lacounty.gov/hipaa/r3COS.htm

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OUTREACH AND ENGAGEMENT FOR INDIVIDUALS AND FAMILIES IN THE COMMUNITY	**I.B.**	**11/1/2006**	**1 of 6**
		REVISION DATE **7/1/2017**	

PURPOSE: To inform Full Service Partnership (FSP) agencies of the outreach and engagement expectations for individuals and families residing in the community.

DEFINITION: Outreach and engagement are services provided to potential FSP clients prior to enrollment in a FSP program. Outreach and engagement services are used to build a relationship between the FSP program and potential client and to determine if the potential client is appropriate for and accepts FSP services.

1. Outreach is defined as the initial step in connecting, or reconnecting, an individual or family to needed mental health services. Outreach is primarily directed toward individuals and families who might not use services due to lack of awareness or active avoidance, and who would otherwise be ignored or underserved. Outreach is a process rather than an outcome, with a focus on establishing rapport and a goal of eventually engaging people in the services they need and will accept.

2. Engagement is defined as the process by which a trusting relationship between a service provider and an individual or family is established. This provides a context for assessing needs, defining service goals and agreeing on a plan for delivering the services. The engagement period can be lengthy and depends on the unique individual needs of consumer.

GUIDELINES:

1. There are three circumstances under which an FSP agency may provide outreach and engagement services to individuals or families residing in the community:

    a. Agency-initiated Outreach to FSP Focal Populations – FSP agencies may choose to conduct outreach and engagement services to individuals and/or families that appear to meet FSP focal population criteria (see II.A. Focal Populations per Age Group for criteria).

        i. The FSP agency will outreach to the prospective client until such time a determination is made as to the individual's appropriateness for, and interest in, a

FSP program.

If the individual/family does not agree to or is determined inappropriate for FSP services, the agency shall ensure linkage to other appropriate services as needed

ii. If the individual/family meets FSP age, focal population and level-of-service criteria and agrees to FSP services, the FSP agency will submit a completed Full Service Partnership Referral and Authorization Form to the appropriate Impact Unit or appropriate Countywide Program Administration requesting pre-authorization to enroll (see III. Referral, Authorization and Enrollment for procedure). For the IFCCS program, the IFCCS agency will return the Disposition form to Children's Systems of Care (CSOC) Administration. For Wraparound FSP, the agency representative will securely email the completed Disposition Form to the Wraparound SA liaison and to the appropriate Countywide Program Administration at Wraparound@dmh.lacounty.gov

b. Walk-in/Self-referral – Prospective FSP clients seeking mental health services may present themselves to an FSP agency. If during the agency's screening process the individual or family appears to meet FSP focal population criteria (see II.A. Focal Populations per Age Group for criteria), the FSP agency may choose to conduct outreach and engagement services to the prospective client. For IFCCS, the agency would have to submit the referral prior to starting outreach and engagement. For Wraparound FSP, self-referrals are processed by the provider. A referral packet is prepared in collaboration with the CSW or DPO and submitted by the provider to the Wraparound SA DMH liaison for case assignment.

i. The FSP agency will outreach to the prospective client until a determination is made as to the

individual's appropriateness for, and interest in, a FSP program. For Wraparound FSP, outreach and engagement in this situation would occur prior to the initiation of the self-referral.

ii. If the individual/family does not agree to or is determined inappropriate for FSP services, the agency shall ensure linkage to other appropriate services, as needed.

iii. If the individual/family meets FSP age, focal population and level-of-service criteria and agrees to FSP services, the FSP agency will submit a completed Full Service Partnership Referral and Authorization Form to the appropriate Impact Unit or appropriate Countywide Program Administration requesting pre-authorization to enroll (see III. Referral, Authorization and Enrollment for procedure). For the IFCCS program, the agency will return the Disposition form to Children's Systems of Care (CSOC) Administration. For Wraparound FSP, the DMH liaison will confirm the appropriateness of the referral and request a FSP slot from Countywide Administration. When an FSP slot is assigned the agency completes and returns the Disposition Form to Countywide Administration and to the Wraparound DMH liaison.

c. Referral from Impact Unit/Service Area Navigator – Referrals for outreach and engagement to a potential FSP client will be sent to the FSP agency by the Impact Unit staff or appropriate Countywide Program Administration through the Service Referral Tracking System (SRTS). The Impact Unit staff will have completed the Full Service Partnership Referral and Authorization Form to the extent possible and the Impact Unit Coordinator will have pre-authorized FSP enrollment based upon preliminary information about the individual (and family, if appropriate). Please note that IFCCS, Wraparound FSP, AOT, and IMHT do not utilize the Impact Unit/Service Area Navigator. For the IFCCS program, CSOC Administration assigns a referral

directly to an IFCCS agency. For Wraparound FSP, all new case assignments are processed by CSAT and Co-located SFC staff, then passed on to the DMH liaison for confirmation of eligibility. Just prior to case assignment by the DMH liaison, the use of an FSP slot is pre-authorized by the appropriate Countywide Program Administration.

i. Upon receiving a referral from the Impact Unit or appropriate Countywide Program Administration for a potential FSP client residing in the community, agency staff shall conduct face-to-face outreach and engagement within seventy-two (72) hours of receiving the referral to determine the individual's appropriateness for, and interest in, a FSP program. Discussions related to the extent and duration of outreach activities shall be held in Impact Unit meetings based the specific needs of the potential FSP client. For the IFCCS program, the agency will conduct face-to-face outreach and engagement within 24 hours (including weekends) of receiving the referral. If the client accepts services, the IFCCS agency should start the intake process and begin IFCCS services immediately. For Wraparound FSP, the provider will be expected to make face-to-face contact with the family within 24 hours for purposes of engagement and official enrollment.

ii. Once a determination has been made, the FSP agency will notify the Impact Unit or appropriate Countywide Program Administration of the outcome of the outreach activities by completing the "FSP Agency" section under "Disposition" on Page 4 of the original Full Service Partnership Referral and Authorization Form and submitting it to the Impact Unit that made the referral. For the IFCCS program, the agency will submit a Disposition form to CSOC Administration indicating the first face-to–face visit and date of enrollment within 7 days of enrollment. For Wraparound FSP, the Disposition form will be completed and returned to the DMH liaison and

appropriate Countywide Program Administration.

iii. If the individual/family does not agree to or is determined inappropriate for FSP services, the agency shall collaborate with the Impact Unit staff and/or individual/family to ensure linkage to other services.

iv. If the FSP agency declines to enroll the eligible individual who has been pre-authorized for enrollment, the agency shall follow III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer.

v. If the individual/family agrees to FSP services and the agency confirms their intent to enroll, the FSP provider is to send the Disposition to the Impact Unit or appropriate Countywide Program Administration (see III. Referral, Authorization and Enrollment for procedure). For Wraparound FSP, the provider needs to return completed Disposition form and Enrollment form to Countywide Administration, DMH liaison, and to DCFS Administration. Not applicable to IFCCS program.

2. Active outreach and engagement lasting longer than 45 days requires consultation with the Impact Unit and Countywide Programs Administration.

3. Claiming for outreach and engagement services must be done through Community Outreach Services (COS). Outreach and engagement services typically fall under the COS category of "Community Client Services" (refer to DMH *Community Outreach Services Manual* for service definitions, codes and claiming instructions).

4. DMH has developed a one-page brochure for each of the four FSP age groups that describes the services available through the FSP program. The brochure includes standardized advisement providing information about the HIPAA Privacy Practices Notice and

how information that is received by the DMH will be handled and maintained. The brochure will be provided by DMH staff to potential FSP clients when, in the opinion of the outreach worker or other staff, it is appropriate and not contraindicated in the process of outreach and engagement to the potential client. The provision of a brochure or similar notification is important to ensure that all prospective clients are aware of the scope of services provided under FSP.

FORMS:

- COS Claim Form in Integrated System (IS): http://lacdmh.lacounty.gov/hipaa/documents/COS_Fillablev4_000.pdf
- COS Claim Form in Integrated Behavioral Health Information System (IBHIS): http://file.lacounty.gov/dmh/cms1_227300.pdf
- Full Service Partnership Referral Form

REFERENCES:

- Community Outreach Services Manual: http://file.lacounty.gov/dmh/cms1_159836.pdf
- COS Claiming Tutorial on IS: http://lacdmh.lacounty.gov/hipaa/r3COS.htm

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

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ELIGIBILITY CRITERIA – FOCAL POPULATIONS PER AGE GROUP	**II.A.**	**8/19/14**	**1 of 6**
		REVISION DATE **7/1/17**	DISTRIBUTION LEVEL

PURPOSE: To establish Full Service Partnership (FSP) eligibility criteria based on focal populations identified in the Mental Health Services Act and developed by the Department of Mental Health and its Stakeholders.

DEFINITION:

1. Child Focal Population (ages 0-15)

    a. Zero to five-year-old (0-5) with serious emotional disturbance (SED) [1] who is at risk of expulsion from pre-school, and/or removal or has been removed from the home by the Department of Children and Family Services (DCFS), and/or has a parent/caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorders.

    b. Child/youth with SED who has been removed or is at risk of removal from their home by DCFS

    c. Child/youth with SED who has a history of drug possession or use

    d. Child/youth with SED who is at risk of commercial sexual exploitation

    e. Child/youth with SED is currently a victim of commercial sexual exploitation

    f. Child/youth with SED who has had three or more DCFS placements within the past 24 months

    g. Child/youth with SED unable to function in the home and/or community setting and is transitioning back to a less structured home or community setting or is at risk of becoming or is currently homeless

    h. Child/youth experiencing one or more of the following at school: truancy or sporadic attendance, suspension and/or expulsion and/or failing classes.

[1] A child/youth is considered seriously emotionally disturbed (SED) if he/she exhibits one or more of the following characteristics, over a long period of time and to a marked degree, which adversely

affects his/her functioning:

(1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(3) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations;
(4) A general pervasive mood of unhappiness or depression;
(5) A tendency to develop physical symptoms or fears associated with personal or school problems. [34 C.F.R. Sec. 300.7(b)(9); 5 Cal. Code Regs. Sec. 3030(i).]

2. Transition-age Youth (TAY) Focal Population (ages 16-25)

A transition-age youth must have a serious emotional disturbance (SED) or a severe and persistent mental illness (SPMI)[2] and meet one or more of the following criteria to request authorization for enrollment:

a. Homeless

b. Youth aging out of:

- Child mental health system
- Child welfare system
- Juvenile justice system

c. Youth leaving long-term institutional care:

- Level 12-14 group homes
- Community Treatment Facilities (CTF)
- Institution for Mental Disease (IMD)
- State Hospitals
- Probation camps
- Jail

c. Youth experiencing first psychotic break.

d. Co-occurring substance abuse issues are assumed to cross-cut along the entire TAY focal population described above.

e. At risk of homelessness: unstable, sporadic housing/multiple placements

f. Currently a victim of commercial sexual exploitation

g. Youth with a history of commercial sexual exploitation

[2]For transition-age youth, severe and persistent mental illness (SPMI) may include significant functional impairment in one or more major areas of functioning, (e.g., interpersonal relations, emotional, vocational, educational or self-care) for at least six (6) months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

3. Adult Focal Population (ages 26-59)

To be considered for enrollment, prospective FSP clients must have a current DSM-5/ICD-10 diagnosis of a major psychiatric disorder *and* demonstrate a need for an intensive FSP program by virtue of their history and current level of functioning.

Prospective FSP clients must also meet *one or more* of the following criteria:

a. Homeless – Client must have been homeless a total of 120 days during the last 12 months.

b. Jail – Client must have been incarcerated on two (2) or more separate occasions that total at least 30 days during the last 12 months and must have a documented history of mental illness prior to incarceration.

c. Acute/Long Term Psychiatric Facilities:

- Institutions of Mental Disease (IMD) – Client must have been admitted to an IMD for a minimum of 6 months during the last 12 months.

- State Hospital – Client must have been admitted to a State Hospital for a minimum of 6 months during the last 12 months.
- Psychiatric Emergency Services (PES) – Client must have at least 10 episodes of emergent care in the past 12 months.
- Urgent Care Center (UCC) – Client must have at least 10 episodes of urgent care in the past 12 months.
- County Hospital – Client must have been hospitalized two (2) or more times totaling at least 28 days of acute psychiatric hospitalizations in the past 12 months.
- Fee For Service Hospital (FFS) – Client must have been hospitalized two (2) or more times totaling at least 28 days of acute psychiatric hospitalizations in the past 12 months.

d. Family Dependent – Client must have at least one (1) year living with family with minimal contact with the mental health system and would be at imminent risk of homelessness, jail or institutionalization without the family's care.

e. At risk of becoming homeless (History of destruction of property, unable to maintain living arrangement, ongoing conflict with neighbors and/or landlord, etc.)

f. At risk of becoming involved with the criminal justice system (Unable to pay fees, presence of warrants, two or more contacts with law enforcement in the past 90 days, etc.)

g. At risk of being psychiatrically hospitalized (Two or more visits to a psychiatric urgent care center, medical emergency room for a psychiatric disorder, or psychiatric emergency room in the past 90 days or at least one encounter with an emergency outreach team in the past 90 days, etc.)

4. Older Adult Focal Population (ages 60+)

To be considered for enrollment, prospective FSP clients must have

a current DSM-5/ICD-10 diagnosis of a major psychiatric disorder *and* demonstrate a need for an intensive FSP program by virtue of their history and current level of functioning.

A client must also meet *one or more* of the following criteria for enrollment :

a. Homelessness – Client was homeless a total of 120 days during the last 12 months.

b. Incarceration – Client was incarcerated on two (2) or more separate occasions that total at least 30 days during the last 12 months and must have documented history of mental illness prior to incarceration.

c. Hospitalizations – Client was hospitalized two (2) or more times totaling at least 28 days of acute psychiatric hospitalizations in the past 12 months.

d. Imminent risk of homelessness, (e.g., at risk of eviction due to code violations),

e. Risk of going to jail, (e.g., multiple interactions with law enforcement over 6 months or more), or;

f. Imminent risk for placement in a Skilled Nursing Facility (SNF) or nursing home, or being released from SNF or nursing home, and without intensive services would not be able to be maintained/released into the community, or;

g. Presence of a co-occurring disorder, (e.g., substance abuse, developmental, medical and/or cognitive disorder), or;

h. Recurrent history or serious risk of abuse or self-neglect, including individuals who are typically isolated, (e.g., APS-referred clients), or;

i. Serious risk of suicide (not imminent)

j. At risk of out of home placement (Fall risk due to chronic health conditions and numerous medications, limited or no social and/or family support, etc.)

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k. At risk of becoming involved with criminal justice system ((Prior legal/incarceration history, little or no family or social support, inadequate or no housing, etc.)

l. At risk of being psychiatrically hospitalized (Suicidal ideation or attempts, Failure to coordinate and take both health and psychotropic medications as prescribed, limited or no connection to non-emergency community services, etc.)

GUIDELINES:

1. FSP enrollment is contingent upon potential clients meeting FSP eligibility criteria, including focal population and level-of-service requirements.

2. Upon determining a client meets Los Angeles County focal population and level-of-service criteria, complete a Full Service Partnership Authorization/Notification Form and submit it to the Impact Unit in the desired Service Area (see III.A. Referral Procedures and the Role of the Impact Unit).

3. Upon determining a client meets at-risk (expanded) focal population, complete a Full Service Partnership Authorization/Notification Form and submit it to the Impact Unit in the desired Service Area (see III.A. Referral Procedures and the Role of the Impact Unit).

FORMS:

- FSP Authorization/Notification Form
- MHSA CSS Full Service Partnership Criteria Expansion

Attachment I

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEM OF CARE - MHSA IMPLEMENTATION & OUTCOMES DIVISION

Mental Health Services Act (MHSA) - Community Services & Supports (CSS)
Full Service Partnership (FSP) Criteria Expansion

Children

Children zero to five (0-5) who:

- are at risk of expulsion from pre-school (e.g. past suspensions)

Children/Youth who:

- are at risk of or have already been removed from the home by DCFS (e.g. seven day notices or multiple placement history)
- are at risk of or are currently involved with the Juvenile Justice system (e.g. contact with law enforcement and/or Juvenile Hall entries)
- are at risk of or are currently a victim of Commercial Sexual Exploitation of Children and Youth (unable to pay fees)

Children/Youth who are unable to function in the home and/or community setting and:

- have psychotic features
- have suicidal and/or homicidal ideation
- have violent behaviors
- have had a recent psychiatric hospitalization(s) within the last six months
- have Co-Occurring Disorder (e.g. substance abuse, developmental or medical disorder)
- are transitioning back to a less structured home/community setting (e.g. from Juvenile Hall and/or Group Home placement)
- are at risk of becoming or who are currently homeless (e.g. eviction, couch surfing, domestic violence, parent unemployment)

Children/Youth who are experiencing the following at school:

- truancy or sporadic attendance (e.g. tickets, School Attendance Review Board)
- suspension or expulsion
- failing classes

Transition Age Youth

- At risk of homelessness: Unstable, sporadic housing/multiple placements
- Currently involved Commercial Sexual Exploitation of Children Youth (CSECY) or youth with a history of CSEC involvement

Adult

Homelessness

An adult who is unable to live to the requirements of their lease, as evidenced by the following and not limited to:

- Loss of funding which will impact sustained housing
- Hoarding, that will lead towards eviction
- Ten day notice to vacate
- Symptoms of illness which impact the ability to keep stable housing
- History of destruction of property
- Unable to maintain current living arrangement
- Ongoing conflict with neighbors and/or landlord
- Couch surfing /living in car less than 120 days
- Inability to pay bills, budget, shop and cook without support

Criminal Justice System

Factors that may contribute to an adult at risk of involvement with the criminal justice system include but are not limited to the following:

- Engagement in unlawful and risky behavior
- Unable to pay fees (i.e. parking tickets, jay walking tickets, court fees, etc.
- Presence of warrants
- Two or more contacts with law enforcement in the past 90 days
- Inability to follow requirements of probation

Adult (continued)

Psychiatric Hospitalization

Factors that may contribute to an adult at risk of psychiatric hospitalization include but are not limited to the following:

- At least one encounter with an emergency outreach team, in the past 90 days
- Two or more visits to a psychiatric emergency room in the past 90 days
- Two or more visits to a Psychiatric Urgent Care Center in the past 90 days
- Two or more visits to a Medical Emergency Room for a psychiatric disorder in the last 90 days

Older Adult

Hospitalization

- Untreated or inappropriately treated mental health, health and/or substance use conditions
- Suicidal ideation or attempts
- Failure to coordinate and take both health and psychotropic medications as prescribed
- Limited or no social, family and/or community support
- Limited or no connection to non-emergency community services
- Food and income insecurity

Institutionalization

- Current community setting or placement does not adequately meet their physical, social, psychological, health or other needs
- Lack of a support system and access to supportive services (IHSS, peer support etc.)
- Multiple chronic health conditions along with a mental health condition

Out of Home Placement

- Often involves family members and others not being comfortable providing care and/or support due to the nature or severity of physical, psychological and/or substance use conditions
- Limited or no social and/or family support.
- Fall risk, due to chronic health conditions and numerous medications (unsteady gait, decreased vision and difficulty ambulating on uneven surfaces)

Incarceration

- Do not have a meaningful way in which to spend their time (volunteer, work, recreation etc.)
- Limited or no income
- Inadequate or no housing
- Inadequate access to mental health, health and substance use services
- Prior legal/incarceration history
- Little or no family or social support
- Absence of peer and other social supports

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
ELIGIBILITY CRITERIA – OPERATIONAL DEFINITIONS AND EXAMPLES	**II.B.**	**11/1/2006**	**1 of 2**
		REVISION DATE	DISTRIBUTION LEVEL

PURPOSE: To provide operational definitions and examples of Full Service Partnership (FSP) eligibility criteria identified in the Mental Health Services Act and established by the Department of Mental Health and its Stakeholders.

DEFINITION: 1. Level of Service

a. Unserved – Those who are not receiving mental health services, particularly those who are from racial/ethnic populations that have not had access to mental health services.

b. Underserved – Those who are receiving some mental health services, though they are insufficient to achieve desired outcomes. For example, Client X has been receiving general out patient services for several years but continues to be homeless and in and out of jail and the hospital. Due to high case loads the staff is unable to provide the necessary services. Clinic Y case managers and clinicians have attempted to meet Client X's frequent requests for assistance with her ancillary needs, which include substance abuse treatment, legal issues, housing, etc. However, the assistance needed to accomplish the above-mentioned ancillary needs would include transporting the client to appointments, seeking housing, negotiating rental contracts, providing help with filling out applications and helping the client navigate through outside agencies/services, such as the court system. These services and the level of support required by this client is far beyond what can be provided by traditional outpatient services. Without the increase in services and more intensive support, it can be expected that Client X would be unable to achieve her goals or make progress in her recovery.

c. Inappropriately Served – Those who are receiving some mental health services though they are inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical or other needs specific to the client. These are often individuals who are from racial/ethnic

populations that have not had access to mental health services due to barriers such as poor identification of their needs, poor engagement and outreach, limited language access, and lack of culturally-competent service within existing mental health programs. For example, Client Y is from the Clatsop Nehalem Tribe and, while he is proficient in English, he prefers to speak in Tillamook, his primary language. Although he has been receiving clinical/case management services in a traditional outpatient clinic, lack of cultural understanding and competency on the part of his clinicians has resulted in misunderstandings. For example, Client Y looks at the floor during conversations with clinicians, even when he is talking. Clinicians have interpreted this as avoidant pathological behavior. This lack of cultural understanding and competency has led to Client Y's increased dissatisfaction with the services and adversely impacted his progress toward recovery.

GUIDELINES:

1. FSP enrollment is contingent upon potential clients meeting FSP eligibility criteria, including focal population and level-of-service requirements.

2. Upon determining a client meets both focal population and level-of-service criteria, complete a Full Service Partnership Referral and Authorization Form and submit it to the Impact Unit in the desired Service Area (see III.A. Referral Procedures and the Role of the Impact Unit).

FORMS:

- Full Service Partnership Referral and Authorization Form

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
ELIGIBILITY CRITERIA – EXCLUSIONARY ISSUES FOR MEDICARE HMO, THIRD PARTY INSURED AND PAROLEES	**II.C.**	**1/8/2008**	**1 of 2**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish guidelines for clients referred to a Full Service Partnership (FSP) program who may be ineligible for FSP enrollment due to benefits criteria for the following categories:

1. HMO Medicare and Third Party-Insured
2. Parolees

DEFINITION:

1. With the exception of a Medi-Cal pre-paid health plan (see Guideline 4 below), an agency that refers a client of a pre-paid health plan, must first look to those entities as responsible for the provision of mental health services as defined by their contracts, unless the prepaid health plan or the client, as appropriate, is willing to pay for the full cost of their care.

2. The California Department of Correction and Rehabilitation (CDCR) is responsible for the State's parole system and the provision of specific and intensive levels of service to its parolees to enable them to successfully reintegrate into the community, including, but not limited to, substance abuse treatment, mental health services, case management and supervision.

GUIDELINES:

1. If a private prepaid health plan member or parolee is being referred to a FSP program, the referral agency should be advised that their client's health care plan or parole agency is responsible for managing their care.

2. In the event that a FSP client is found out to be a beneficiary of a prepaid health plan or a parolee, the client must be immediately referred back to the referring agency, health plan, and/or parole agency for disposition and continued services. However, the client can continue FSP services with prior authorization from their private prepaid health plan, if one of the following conditions exists:

    a. Mental health services are not a covered benefit of the health plan.
    b. The client has exhausted the allowable mental health benefits under their specific insurance plan for the coverage year.
    c. The client requires emergency care (FSP providers should contact the client's private prepaid health plan for emergency treatment authorization and billing instructions within 24-48

hours of the emergency service being rendered.)

d. None of the above conditions exists and the private prepaid health plan authorizes the clinic to provide services.

3. Providers are not required to refer clients with Medi-Cal in addition to private insurance back to the insurance company for services. Call the insurance company for authorization and billing instruction prior to providing non-emergency service and then bill the insurance for services. The service may be billed to Medi-Cal after the insurance has approved or denied the claim. The client is not to be charged for the cost of services left unpaid by the insurance; Medi-Cal will take on that responsibility on the client's behalf (see DMH Revenue Management Bulletin No. 13-013).

4. The above definitions and guidelines do not apply to beneficiaries with Medi-Cal pre-paid health plans (e.g., Health Maintenance Organization (HMO), Prepaid Health Plan (PHP), Managed Care Plan (MCP), Primary Care Physician Plan (PCCP), and Primary Care Case Management (PCCP)). These beneficiaries are to be provided services as any other Medi-Cal beneficiary.

AUTHORITY/ REFERENCE:

- DMH Policy and Procedure 801.06 (9/1/04)
- DMH Revenue Management Bulletin No. 13-013 (1/17/13)
- California Department of Correction and Rehabilitation Parole Service Description (1/06)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
FAMILY SUPPORT SERVICES	**II.D.**	**11/1/2006**	**1 of 3**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish Family Support Services eligibility criteria and service delivery standards for Children's Full Service Partnership (FSP) Programs.

DEFINITIONS: Family Support Services (FSS) are voluntary mental health support services provided to the significant support persons of a child enrolled in a Children's FSP Program.

Significant support persons are individuals such as a parent/caregiver/guardian, sibling, family relative or other person living in the same household as the FSP enrolled child who has a significant impact on the success of the child's treatment and outcomes.

GUIDELINES:

1. Eligibility Criteria

Significant support persons (typically family members) of a FSP enrolled child who have their own ongoing mental health needs which require more than collateral services and who:

a. Has Medi-Cal and does not meet Medical Necessity for his/her own mental health services

OR

b. Is uninsured and does not meet Target Population for his/her own mental health services

2. Range of Services

a. The FSS program should offer eligible significant support persons a full array of clinical services that complement the FSP program's peer support and parent advocacy services and include individual, couples and group therapy, psychiatry/medication support, crisis intervention, case management/linkage, and parenting education.

b. Treatment should incorporate services for substance abuse and domestic violence whenever necessary.

3. Service Delivery Standards

Service delivery standards should:

a. Integrate the family member and/or significant support person's treatment with that of the FSP enrolled child associated with them

b. Utilize joint planning to address both individual and family needs

c. Focus on wellness and empowering parents/caregivers to fully participate in their family's lives and within their communities

d. Target the reduction or elimination of mental health symptoms

4. Claiming and Recordkeeping

FSP agencies have two options for claiming FSS services through the Integrated System (IS) and Integrated Behavioral Health Integrated System (IBHIS).

Please note, that FSP agencies must email the FSS Countywide Notification Form (See Attachment # 8) to the Children's Systems Of Care (CSOC) Administration inbox at CSOCFSP@dmh.lacounty.gov prior to initiating any FSS services.

Reference Source: DMH Organizational Provider's Manual

Claiming Method # 1:

Claiming FSS is through Community Outreach Service (COS). (See Attachment # 7)

- All FSS COS claims must include the FSP enrolled child's client ID and IS number on:

  a) the hardcopy COS form in "Agency Name" and
  b) in the (IS-COS/IBHIS-COS) "Service Location Information"

- All FSS COS claims must also identify the relationship (e.g. grandmother, mother, father, sibling) between the FSS recipient and the FSP enrolled child by entering a relationship identifier on:

  a) the hardcopy COS form in the "Service Type Description" box and
  b) in the (IS-COS/IBHIS-COS) "Service Type Description" field

Claiming Method # 2:

The treating clinician opens a record in the IS or IBHIS and establishes a Client ID# for the FSS recipient.

Enter "NO" at the Medi-Cal option because Mode 15 Service Function Codes are included in each agency's IS Provider File for Targeted Case Management, Mental Health Services (individual, group, collateral), Medication Support and Crisis Intervention.

- FSS provider agencies are required to maintain separate clinical records for FSS recipients that comply with the current rules governing the documentation of direct services that are reimbursed through County General Funds (CGF).

- FSS provider agencies are also required to complete and maintain the following clinical record forms:

  - Consent for Services
  - Assessment
  - Client Treatment Plan
  - Progress Notes

(See Attachments 1 – 6)

ATTACHMENTS:

Clinical Forms can be found:
http://dmh.lacounty.gov/wps/portal/dmh/clinical_tools/clinical_forms

#1 - Adult Full Assessment (Forms MH 532)

#2 - Child/Adolescent Full Assessment (Forms MH 533)

#3 - Assessment for Clients Age 0-5 (Forms MH 645)

#4 - Client Treatment Plan (Forms MH 651 & 636)

#5 - Client Treatment Plan Addendum (Forms MH 636A)

#6 - Change of Diagnosis (Form MH 501)

#7 - COS Form Samples

#8 - Family Supportive Services (FSS) Countywide Notification Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
CHILD FULL SERVICE PARTNERSHIP

FAMILY SUPPORTIVE SERVICES COUNTYWIDE NOTIFICATION FORM

Instructions: Completed forms must be submitted to Children's Systems Of Care (CSOC) Administration through secure email to CSOCFSP@dmh.lacounty.gov prior to initiating FSS services. A CSOC staff member will contact you within 5-business days. Please make sure to write in the Subject Line: FSS Countywide Notification Form in order to prevent delays in processing your request.

Name of FSP Child:			
Date of Birth:		IS#/IBHIS#:	
Name of Provider:			
Provider #:		Service Area:	
Name of Person Completing Form:		Title: (i.e. therapist)	
Email:		Phone Number:	
FSS Potential Client:		Date of Birth:	
Relationship to FSP Child: (i.e. parent, sibling)		Potential client and/or caregiver aware of FSS referral:	☐ Yes ☐ No
What services is potential client receiving?		Potential client has Medi-Cal?	☐ Yes ☐ No

Date Sent to CSOC Administration:

Date Received by CSOC Administration:

Date Processed by CSOC Administration:

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

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REFERRAL PROCEDURES	**III.A.**	**1/17/2008**	**1 of 9**
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PURPOSE:

To establish referral procedures for individuals referred to Full Service Partnership (FSP), other specialized FSP programs, and identify the special exception for American Indians and Veterans and their families. There are several routes by which clients can be referred to a FSP program:

1. FSP agencies identify through outreach individuals who may qualify and submit Full Service Partnership Referral and Authorization Form to the Impact Unit for pre-authorization to enroll.

2. Individuals may be referred to the Impact Unit by a non-FSP entity, (e.g., mental health services providers, social service agencies, and members from the community). The Impact Unit will pre-authorize enrollment of the client and will direct these referrals to the appropriate agency for enrollment.

3. For IFCCS, WraparoundFSP, AOT, and IMHT services, individuals must be referred directly to the appropriate Countywide Program Administration who will direct these referrals to an agency for enrollment.

DEFINITION:

1. Pre-authorization – Referrals are screened by the Impact Unit or appropriate Countywide Program Administration for specialized FSP programs to ensure they meet criteria for a FSP program. Appropriate referrals are pre-authorized and assigned to FSP agency for the initiation of Outreach & Engagement services.

2. Authorization – Countywide Program staff makes the final determination as to the appropriateness of the individual for FSP services and indicates approval of authorization.

   Notification – If a client meets only state (at-risk) FSP criteria , yet is appropriate for FSP level of care, a notification form can be completed by the FSP program once the individual begins FSP services, and notification form is completed within 24 hours of enrollment.

4. Impact Unit – The Service Area (SA) Impact Unit is comprised of Impact Unit Teams that process referrals, link clients to community resources, and provide consultation and follow-up. Impact Units can refer clients directly to intensive service providers. (For older adults, see III.A.1. Older Adult Centralized Impact Unit.)

5. Countywide Program Administration - The following is a list of the Departments/Bureaus/Divisions/Unit that oversee FSP and Specialized FSP programs:

    a. Children's Systems Of Care (CSOC) Administration
    b. Transitional Age Youth Systems Of Care (TAYSOC) Administration
    c. Adult Systems Of Care (ASOC) Administration
    d. Older Adult Systems Of Care (OASOC) Administration
    e. Child Welfare Division (CWD)
    f. Countywide Resource Management (CRM)
    g. Countywide Housing, Employment and Education Resource Development (CHEERD).

6. Service Request Tracking System (SRTS) - SRTS is used by all LACDMH provider and administrative linkage sites for linkage to mental health services. In addition, SRTS is a Department-approved electronic process used to document an initial request for specialty mental health services. All requests for FSP services shall be done through SRTS except for IMHT.

7. IFCCS Referral Portals – points of entry where Katie A. Subclass Members can be referred for IFCCS services. These portals are from DMH or Department of Children and Family Services (DCFS) only. (Please refer to IFCCS Service Exhibit for additional information).

GUIDELINES: (For older adults, see III.A.2. Older Adult FSP Referral Procedure.)

1. DMH authorization must be obtained prior to an agency enrolling an individual into a FSP program, opening a FSP episode on the Integrated System (IS) or Integrated Behavioral Health Information System (IBHIS) or providing any billable

services other than outreach. FSP agencies must obtain pre-authorization from the designated Impact Unit Coordinator and authorization from the appropriate Countywide Programs Administration. If a client meets only state (at-risk) FSP criteria, yet is appropriate for FSP level of care, a notification form can be completed by the FSP program once the individual begins FSP services. The notification form is entered into SRTS by the FSP program to the SA Navigator within 24 hours of enrolling the client in services to be forwarded to the respective countywide administrative unit. FSP Notification only applies to TAY, Adult and Older Adult FSP.

2. If a client is currently receiving outpatient mental health services and has an open episode on the IS or IBHIS, but is underserved or inappropriately served, the requesting agency must include written justification on the Full Service Partnership Referral and Authorization Form for a client to be considered for enrollment in a FSP program. Written justification must detail why the individual needs the supportive services of a FSP, such as the frequency of hospitalizations, incarcerations or episodes of homelessness.

The following referral procedures outline the three routes by which clients can be referred to a FSP program:

<u>Referral Procedure 1</u>:

1. FSP agency will outreach and engage clients that appear to meet focal population criteria.

2. When client agrees to participate in a FSP program, the FSP agency will complete the Full Service Partnership Referral and Authorization Form and submit it to the Impact Unit Coordinator for pre-authorization for enrollment. Incomplete or altered referral forms will be refused and returned to the referral source with a request to re-submit once the referral form has been completed/corrected.

3. Impact Unit Coordinator will screen referral for FSP eligibility within three (3) business days. Clients that meet FSP eligibility criteria will be pre-authorized and forwarded to

appropriate Countywide Program Administration. FSP agency will be notified by Impact Unit Coordinator of clients who do not meet FSP eligibility criteria and the FSP agency will collaborate with the SA Navigator to ensure linkage to other services.

4. Countywide Program staff will review the referral and pre-authorization information and will notify the FSP agency and SA Impact Unit of authorization for enrollment (or lack thereof) within two (2) business days. Impact Unit Teams that have not received a response from appropriate Countywide Program Administration within two (2) business days of sending a referral for authorization shall call to follow up. If appropriate Countywide Program Administration does not respond within three (3) business days of receipt of the referral, it may be considered authorized for enrollment. If Countywide Programs finds the client does not meet criteria for authorization, but meets at-risk criteria and needs FSP level of service, the referral will be processed as a notification referral.

Referral Procedure 2:

1. For FSP referrals by a non-FSP entity, the Impact Unit Coordinator will obtain contact information and complete the Full Service Partnership Referral and Authorization Form.

2. Impact Unit Coordinator will screen referral for FSP eligibility within three (3) business days. Clients that meet FSP eligibility criteria will be pre-authorized and forwarded to an FSP agency with available slots for outreach and engagement.

3. The FSP agency to which the individual was referred will outreach to the prospective client within seventy-two (72) hours of receiving the referral and until such time a determination is made as to the individual's appropriateness for, and interest in, a FSP program. Discussions related to the extent and duration of outreach activities shall be held in Impact Unit meetings based the specific needs of the individual client.

a. If the referred individual is in an institution, (e.g., county or fee-for-service (FFS) acute hospital; Institutions for Mental Disease (IMD); Enriched Residential/IMD Step Downs; Skilled Nursing Facility (SNF); State Hospital (SH); Psychiatric Health Facility (PHF); Jail; Juvenile Hall; Probation camp; Department of Juvenile Justice (DOJJ); or Short Term Residential Treatment Programs (STRTP), outreach and engagement should include communication between the FSP and the institution, regular contact with the client and, for minor clients, the parent/guardian, and participation in the client's discharge plan (see I.A. Outreach and Engagement for Clients in Institutions).

4. Once a determination has been made, the FSP agency will notify the Impact Unit of the outcome of the outreach activities.

    a. If the individual does not agree to or is determined inappropriate for FSP services, the FSP agency will collaborate with the SA Navigator to ensure linkage to other services.

    b. If the FSP agency declines to enroll a client who has been pre-authorized for enrollment, then III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer shall be followed.

    c. If the individual agrees to FSP services, the FSP agency will confirm with the Impact Unit Coordinator their intent to enroll the individual. The Impact Unit will forward the completed Full Service Partnership Referral and Authorization Form to appropriate Countywide Program Administration for enrollment authorization or notification processing.

5. Countywide Program staff will review the referral and pre-authorization information and will notify the FSP agency and SA Impact Unit of authorization for enrollment (or lack thereof) within two (2) business days. Impact Unit Teams that have not received a response from appropriate Countywide Program Administration within two (2) business days of sending a referral for authorization shall call to follow up. If appropriate Countywide Program Administration does not respond within three (3) business days of receipt of the referral, it may be considered authorized for enrollment. If Countywide Programs finds the client does not meet criteria for authorization, but meets at-risk criteria and needs FSP level of service, the referral will be processed as a notification referral.

Referral Procedure 3:

1. For FSP referrals by a non-FSP entity, the Impact Unit Coordinator will obtain contact information and complete the Full Service Partnership Referral and Authorization Form.

2. Impact Unit Coordinator will screen referral for FSP eligibility within three (3) business days. Clients that meet FSP eligibility criteria and agree to FSP services will be pre-authorized and forwarded to an FSP agency with available slots.

3. Upon receiving the referral, the Impact Unit will forward the completed Full Service Partnership Referral and Authorization Form to appropriate Countywide Program Administration for enrollment authorization.

4. Countywide Program staff will review the referral and pre-authorization information and will notify the FSP agency and SA Impact Unit of authorization for enrollment (or lack thereof) within two (2) business days. Impact Unit Teams that have not received a response from appropriate Countywide Program Administration within two (2) business days of sending a referral for authorization shall call to follow up. If appropriate Countywide Program Administration does not respond within three (3) business days of receipt of the

referral, it may be considered authorized for enrollment.

If Countywide Programs finds the client does not meet criteria for authorization, but meets at-risk criteria and needs FSP level of service, the referral will be processed as a notification referral.

5. If the FSP agency declines to enroll a client who has been pre-authorized for enrollment, then III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer shall be followed.

Referral Procedure 4:

1. Appropriate Countywide Program Administration receives an IFCCS referral from DMH or Department of Children and Family Services (DCFS) Portals. If client meets focal population, the referral will be assigned to an IFCCS agency within 48 hours (business hours).

    a. Please note that on some occasions IFCCS agencies can make internal referrals as clients come seeking services and are deemed appropriate for IFCCS. In this instance, the IFCCS agency is to submit an IFCCS referral prior to enrolling and initiating services.

2. IFCCS agency will conduct face-to-face outreach and engagement within 24 hours (including weekends) of receiving the referral.

3. If the client meets IFCCS criteria and accept services, IFCCS team can enroll client and begin IFCCS services immediately.

4. IFCCS agency must submit the Disposition form indicating the first face-to-face and date of enrollment within 7 business days.

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Referral Procedure 5:

1. FSP agency will outreach and engage clients that appear to meet focal population at-risk criteria.

2. When client agrees to participate in a FSP program, the FSP agency will complete the Full Service Partnership Notification Form and submit it to the Service Area Navigator for enrollment.

3. Service Area Navigator will screen and forward appropriate notification referral to countywide administration for enrollment processing. FSP agency will be notified by Impact Unit Coordinator of clients who do not meet FSP eligibility criteria and the FSP agency will collaborate with the SA Navigator to ensure linkage to other services.

4. Countywide Program staff will review the notification referral to ensure client is not already enrolled in FSP elsewhere, and will notify the FSP agency and SA Impact Unit of enrollment processing within two (2) business days.

5. If the client is found to meet both county focal population and state at-risk criteria, the notification referral will be processed through authorization.

6. Notification referrals that do not meet FSP at-risk criteria or do not require FSP level of service can be returned by either Service Area Navigation/Impact Team or respective Countywide Administration for referral to other appropriate services.

7. The Service Area District Chief can impose a limit on notification referrals in order to ensure capacity to serve the highest need clients in the community.

Once the FSP agency has obtained the required authorization, it may open the client episode in the IS or IBHIS and OMA (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com).

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SPECIAL EXCEPTION:

1. Referrals for American Indians of all age groups who want/need culturally specific mental health services will be forwarded to the Service Area 7 Impact Unit for authorization rather than to the Impact Unit located in the Service Area where the individual resides.

2. Referrals for Veterans and their families who want/need culturally specific mental health services, regardless of VA eligibility status and military discharge, can refer to the Veterans and Loved Ones Recovery (VALOR) FSP program by forwarding referrals to the designated Service Area 4 Impact Unit for pre-authorization and authorization.

FORMS:

- FSP Authorization/Notification Form

REFERENCES:

- http://dmhoma.pbworks.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OLDER ADULT CENTRALIZED IMPACT UNIT	**III.A.1.**	**7/1/2017**	**1 of 2**

PURPOSE: To clearly define the roles and responsibilities for the Older Adult Centralized Impact Unit (CIU) related to the Older Adult Full Service Partnership (FSP) program.

DEFINITION: The Older Adult CIU is comprised of Department of Mental Health (DMH) staff members and Older Adult FSP providers. The CIU is the body responsible for identifying clients who meet eligibility criteria for a FSP program. CIU members engage in regular coordination of care meetings known as Impact Meetings to review referrals, process enrollment, monitor progress, and disenroll clients from FSP programs as appropriate. The CIU serves as an advisory and care coordination body; ultimate responsibility for enrollment and disenrollment rests with DMH.

GUIDELINES: CIU Membership

1. Attendance to the CIU may vary depending on the circumstances of each individual case. Core members who must be present in order to convene a CIU meeting include:

    a. DMH Older Adult FSP Impact Coordinator
    b. DMH Older Adult Program Clinical Supervisor or designee
    c. Representatives from Older Adult FSP Provider Teams

2. Participation of additional individuals may be arranged, as needed, according to the specific care coordination requirements of each potential FSP enrollee. Occasional participants may include, but are not limited to, representatives such as staff from referring agencies; client or family member(s); housing providers; and/or the Office of the Public Guardian.

CIU Membership Roles

1. Impact Coordinator

    a. The Impact Coordinator is expected to have clinical expertise in addressing concerns of Older Adults with severe mental illness.
    b. Responsible for the initial screening of a referral. When a referral

is received that provides adequate preliminary information, (i.e., referral form is completed correctly; referral meets general criteria for FSP; client has had a clinical evaluation prior to referral), then the Impact Coordinator will pre-authorize the referral and contact the referring party to inform them of the client's disposition.

c. Responsible for facilitation of bi-weekly Impact Meetings where cases that have been pre-authorized are presented by the respective FSP provider. The Impact Coordinator has responsibility for providing final approval of client enrollment in FSP program.

2. DMH Older Adult Program Supervisor

The Older Adult Program Supervisor provides clinical oversight to the Impact process. The supervisor is expected to have clinical expertise with Older Adults who have a severe mental illness.

3. Representatives from Older Adult FSP Provider Teams

Attend Impact Meetings to participate in the authorization and enrollment of clients in an appropriate FSP program that best meets the client's needs.

4. Occasional CIU Participants

Includes representative(s) from referring agency(ies) and/or representative(s) of client or family member. These participants will provide information about the client's needs for coordination of care and treatment planning purposes.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OLDER ADULT FULL SERVICE PARTNERSHIP REFERRAL GUIDELINES	**III.A.2.**	**7/1/2017**	**1 of 4**

PURPOSE: To establish procedures for referrals to Older Adult Full Service Partnership (FSP) programs.

DEFINITION: All clients referred to an Older Adult FSP will be processed following one of two procedures described below:

(A) Clients who have had clinical assessments completed prior to FSP referral, or

(B) Clients who have not had a clinical assessment prior to referral for FSP services.

GUIDELINES: REFERRAL PROCEDURE (A):

Referring party is a mental health provider (inpatient or outpatient) and has completed a clinical assessment prior to referral. Referrals can be made via FSP Referral and Authorization Form, or via Notification Form.

FSP Referral and Authorization Form

1. Referring party submits completed FSP Referral and Authorization Form to Impact Unit (via SRTS or paper copy).
    a. Inpatient – Referral party will submit the completed Full Service Partnership Referral and Authorization Form as well as the following: initial psychiatric evaluation, history and physical evaluation, multidisciplinary notes, medications and laboratory results.
    b. Outpatient – Referral party will submit the completed Full Service Partnership Referral and Authorization Form as well as the following, when feasible: Adult Full Assessment, multidisciplinary notes and medications.

2. Impact Unit Coordinator screens the referral for FSP eligibility criteria.

a. If Impact Unit Coordinator finds the referral to meet FSP criteria, the referral will be pre-authorized and assigned to a specific FSP provider based upon the geographic area in which the prospective client resides or will be residing. The FSP provider will provide outreach and engagement to develop rapport with prospective client, complete a comprehensive assessment, and obtain agreement from prospective client for FSP services.

b. If Impact Unit Coordinator finds that referral information is insufficient to determine whether FSP eligibility criteria have been met, Impact Unit Coordinator will contact the referring party to request additional information.

c. In instances where FSP eligibility criteria is not met, either during initial referral screening or during outreach and engagement phase, Impact Unit Coordinator will return referral to source and provide appropriate information and linkage.

d. For referrals that meet criteria, FSP provider will schedule case presentation at the Older Adult CIU meeting in order to arrive at a determination regarding authorization for enrollment.

e. Impact Unit Coordinator will respond to non-emergent referrals within 72 hours of receipt of referral and within 24 hours of referrals from hospitals and IMDs when feasible.

<u>Referrals via Notification Form</u>

1. The Notification process is an alternate way of receiving FSP referrals. Upon receipt of the Notification Form, the Impact Coordinator completes the appropriate enrollment field in the SRTS and logs receipt into the CIU's internal tracking system.

REFERRAL PROCEDURE (B):

Referring party is not a mental health provider, (e.g., Adult Protective Services caseworker; senior apartment manager or ombudsman; Code Enforcement; law enforcement; Animal Control, Public Defender or prosecutors; city or county officials; etc.) and a clinical assessment has not been completed prior to referral.

1. Referring party submits completed Full Service Partnership Referral and Authorization Form to Impact Unit Coordinator for review.

2. Impact Unit Coordinator screens the referral for FSP eligibility criteria.

    a. If Impact Unit Coordinator finds the referral to meet FSP criteria, the referral will be assigned to a specific FSP provider based upon the geographic area in which the prospective client resides or will be residing. The FSP provider will provide outreach and engagement to develop rapport with prospective client, complete a comprehensive assessment, and obtain agreement from prospective client for FSP services.

    b. If Impact Unit Coordinator finds that referral information is insufficient to determine whether FSP eligibility criteria have been met, Impact Unit Coordinator will contact the referring party to request additional information.

    c. In instances where FSP eligibility criteria is not met, either during initial referral screening or during outreach and engagement phase, Impact Unit Coordinator will return referral to source and provide appropriate information and linkage.

d. For referrals that meet criteria, FSP provider will schedule case presentation at the Older Adult CIU meeting in order to arrive at a determination regarding authorization for enrollment.

e. Impact Unit Coordinator will respond to non-emergent referrals within 72 hours of receipt of referral and within 24 hours of referrals from hospitals and IMDs when feasible.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
ROLE OF THE IMPACT UNIT	**III.B.**	**11/1/2006**	**1 of 1**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish guidelines and expectations of participating in an impact unit and the role of the impact unit in determining the appropriate disposition for clients with intensive service needs, (e.g., FSP, IFCCS, AOT, IMHT, and Wraparound FSP).

DEFINITIONS:

1. Impact Unit – The Service Area (SA) Impact Unit is comprised of Impact Unit Teams that process referrals, link clients to community resources, and provide consultation and follow-up. Impact Units can refer clients directly to intensive service providers. (For older adults, see III.A.1. Older Adult Centralized Impact Unit.)

2. Impact Unit Coordinator – The Impact Unit Coordinator has the lead responsibility for processing referrals to FSP programs and also track FSP and other referrals to ensure linkage to MH services. The coordinator is a representative of either a SA or Countywide program (see X. DMH Contacts) and is part of the Impact Unit Team. The coordinator provides pre-authorization for enrollment into the FSP program, triages referrals to SA Navigators, and ensures all referrals to their SA are screened and linked to appropriate services and supports.

3. Impact Unit Teams – Impact Unit Teams are comprised of SA representatives, such as SA Navigators, Parent Advocates, Housing Specialists, Hospital Liaisons, intensive services providers, and hospital/IMD representatives. The team's responsibility is to discuss and determine the appropriate disposition for clients with intensive service needs, (e.g., FSP, IFCCS, AOT, IMHT, and Wraparound FSP).

4. Service Area Navigator – The SA Navigators were created through the MHSA Community Services and Supports (CSS) Plan to assist individuals and families in accessing mental health and other supportive services and to network with community-based organizations in order to strengthen the array of available services. SA Navigators provide information and education to the community about all MH services available.

GUIDELINES: (For older adults, see III.A.1. Older Adult Centralized Impact Unit. For IMHT and IFCCS FSP, the SA Impact Unit will prescreen all referrals for IMHT and IFCCS FSP eligibility criteria. The referral will then be sent to IMHT and IFCCS FSP Program Administration. Within (3) three business days,

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IMHT and IFCCS FSP Program Administration will make the final disposition regarding the individual meeting IMHT and IFCCS FSP eligibility criteria. If the client meets criteria the referral will be assigned to an IMHT and IFCCS FSP provider.)

1. DMH authorization must be obtained prior to an agency enrolling an individual into an FSP program, opening a FSP episode on the Integrated System (IS) or Integrated Behavioral Health Information System (IBHIS) or providing any billable services other than outreach. FSP agencies must obtain pre-authorization from the designated Impact Unit Coordinator and authorization from the appropriate Countywide Program Administration.

2. Impact Unit Coordinator will screen referral for FSP eligibility within three (3) business days. Clients that meet FSP eligibility criteria will be pre-authorized and forwarded to the appropriate Countywide Program Administration. FSP agency will be notified by Impact Unit Coordinator of clients who do not meet FSP eligibility criteria and the FSP agency will collaborate with the SA Navigator to ensure linkage to other services.

3. Countywide Program staff will review the referral and pre-authorization information and will notify the FSP agency and SA Impact Unit of authorization for enrollment (or lack thereof) within two (2) business days. Impact Unit Teams that have not received a response from appropriate Countywide Program Administration within two (2) business days of sending a referral for authorization shall call to follow up. If appropriate Countywide Program Administration does not respond within three (3) business days of receipt of the referral, it may be considered authorized for enrollment.

SPECIAL EXCEPTION:

Referrals for American Indians of all age groups who want/need culturally specific mental health services will be forwarded to the Service Area 7 Impact Unit for authorization rather than to the Impact Unit located in the Service Area where the individual resides.

Referrals for Veterans and their families who want/need culturally specific mental health services, regardless of VA eligibility status and military discharge, can refer to the Veterans and Loved Ones Recovery (VALOR) FSP program by forwarding referrals to the designated Service Area 4 Impact Unit for pre-authorization and authorization.

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COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
PROCEDURE FOR FILING APPEALS RELATED TO FSP CLIENT ENROLLMENT, DISENROLLMENT OR TRANSFER	**III.C.**	**11/1/2006**	**1 of 1**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish guidelines for agency appeals in the event Full Service Partnership (FSP) agencies and DMH Impact Unit and/or appropriate Countywide Program Administration fail to reach agreement regarding client enrollment, disenrollment or transfer.

GUIDELINES:

1. Agencies are expected to adhere to guidelines regarding enrollment, disenrollment and transfer of FSP (see III. Referral, Authorization and Enrollment Guidelines). In the event that a disagreement occurs about an enrollment, disenrollment or transfer decision, Impact Unit or appropriate Countywide Program Administration shall attempt to reach consensus regarding the client's disposition through discussion with the FSP agency.

2. In the event that consensus is not reached, an agency can elect to appeal an enrollment/disenrollment/transfer decision, by completing the Full Service Partnership Appeal Form and submit it to the Service Area District Chief (see X. DMH Contacts) overseeing the area in which the agency is delivering FSP services. The Service Area District Chief will confer with the age-appropriate Countywide District Chief and/or lead contract District Chief to make a joint determination regarding the disposition.

Conditions under which an appeal may be filed include the following:

1. DMH Impact Unit or appropriate DMH Countywide Program Administration refers an eligible client to an FSP agency that declines to enroll the individual.

2. FSP agency requests authorization to enroll a client and DMH Impact Unit or appropriate DMH Countywide Program Administration denies permission to enroll.

3. FSP agency requests authorization to disenroll a client and DMH Impact Unit or appropriate DMH Countywide Program Administration denies permission to disenroll.

4. FSP agency requests authorization to transfer a client between FSP programs and DMH Impact Unit or appropriate DMH Countywide Program Administration denies permission to transfer.

FORMS:

- Full Service Partnership Appeal Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS - FULL SERVICE PARTNERSHIP
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SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
FSP Reinstatement and Re-Establishment	**III.D.**	**8/1/2010**	**1 OF 4**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To provide guidelines and procedures for the reinstatement and re-establishment of clients into the Full Service Partnership (FSP) program up to one year after a client disenrolls from an FSP program.

DEFINITIONS: FSP Reinstatement is a reinstatement of FSP authorization within 60 days of disenrollment when an individual demonstrates a need for FSP level intensive services. A client reinstated to a FSP program will have their disenrollment status removed and continue with FSP services. Please note, a reinstatement can only occur if the client is being re-enrolled in the same type of FSP program, (i.e. FSP to FSP, IFCCS to IFCCS, IMHT to IMHT, Wraparound FSP to Wraparound FSP, etc.)

For an individual to reinstate into the FSP program, they must meet all of the following criteria:

a. The individual must have disenrolled from FSP within the past 60 days.

b. The individual's clinical needs cannot be met in a lower level of service (i.e. outpatient or other less intensive in-home service)

c. The individual must require a FSP level of intensive services to remain in the community.

d. The individual must be at-risk for meeting the appropriate age group FSP criteria for services. Because the individual was previously enrolled in a FSP program in the past 60 days, he/she does not need to meet Full FSP criteria for reinstatement.

FSP Re-establishment occurs when an individual who has been disenrolled from FSP within the previous 12 months presents a need for a FSP level of intensive services. A re-establishment requires the completion of a new Full Service Partnership Referral and Authorization Form, however the individual will not have to meet full FSP criteria for enrollment in the same way as an individual entering the FSP program for the first time. One

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exception is for the IFCCS and Wraparound FSP programs, the client must meet Katie A. Subclass Criteria.

For an individual to re-establish into FSP, they must meet all of the following criteria:

a. The individual must have disenrolled from FSP within the past 12 months.

b. The individual's clinical needs cannot be met in a lower level of service (i.e. outpatient or other less intensive in-home service).

c. The individual must require a FSP level of intensive services to remain in the community.

d. The individual must be at-risk for meeting the appropriate age group FSP criteria for services. Because the individual was previously enrolled in the FSP program in the past 12 months, he/she does not need to meet full FSP criteria for re-establishment.

e. Space must be available in the FSP program for the individual to re-establish in the FSP program.

PROCEDURE: FSP Reinstatement

a. Upon determination that the client meets reinstatement criteria, the FSP provider will complete a FSP Reinstatement Request Form and submit the form to the age appropriate Impact Unit Coordinator or appropriate Countywide Program Administration for pre-authorization of reinstatement.

b. The Impact Unit Coordinator or appropriate Countywide Program Administration will review the reinstatement request within five (5) business days of receipt to determine the appropriateness of the reinstatement request.

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c. If the client is determined appropriate for reinstatement, the Impact Unit will forward the completed and signed FSP Reinstatement Request Form to appropriate Countywide Program Administration for Authorization. Please note that this step does not apply for programs who receive direct authorization from Countywide Program Administration.

d. For programs that utilize the Impact Unit, appropriate Countywide Program Administration will review the request for reinstatement and pre-authorization information and will notify FSP programs and the Impact Unit of authorization within two (2) business days. Will also change client status in the FSP Referral Tracker to Active and Disenrollment should be Not-Authorized.

e. For programs that receive referrals from appropriate Countywide Program Administration, if the client is determined appropriate for reinstatement, authorization will be sent directly to the FSP program to begin services.

f. If a client is reinstated to a FSP program, the provider must delete the Key Event Change indicating disenrollment from the FSP program in the OMA.

g. If the Impact Unit or appropriate Countywide Program Administration does not pre-authorize the reinstatement, the request will be returned to the agency.

h. If the appropriate Countywide Program Administration does not authorize the reinstatement, the denial is signed and forwarded to the appropriate Impact Unit. The denial is then forwarded to the FSP provider. Please note that this step does not apply for programs who receive direct authorization from appropriate Countywide Program Administration.

i. If the FSP agency does not agree with the decision of the Impact Unit or appropriate Countywide Program

Administration, then the agency may file an appeal. (See III.C. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment, or Transfer)

FSP Re-Establishment

a. Upon determination that the client meets re-enrollment criteria, the FSP provider will complete a Full Service Partnership Authorization/Notification Form and submit to the age appropriate Impact Unit Coordinator or appropriate Countywide Program Administration for pre-authorization of re-establishment. The program will use the Focal Population most appropriate for the individual's current status.

b. The Impact Unit Coordinator or appropriate Countywide Program Administration will review the re-enrollment request within five (5) business days of receipt to determine the appropriateness of the re-enrollment request.

c. If the Impact Unit or appropriate Countywide Program Administration does not authorize the re-establishment, the request will be returned to the FSP agency.

d. If the client is determined appropriate for re-enrollment, the Impact Unit will forward the completed and signed Full Service Partnership Referral and Authorization Form to appropriate Countywide Program Administration for Authorization. The client will have a new authorization date, but will retain the previous partnership date for OMA purposes. Because the individual was enrolled within the past year, OMA data must continue to be collected under the previous baseline. Please note that this step does not apply for programs who receive direct authorization from appropriate Countywide Program Administration.

e. For programs that receive referrals from appropriate Countywide Program Administration, if the client is

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determined appropriate for re-establishment, authorization will be sent directly to the FSP program to begin services. The client will have a new authorization date, but will retain the previous partnership date for OMA purposes. Because the individual was enrolled within the past year, OMA data must continue to be collected under the previous baseline.

f. For programs that utilize the Impact Unit, appropriate Countywide Program Administration will review the request for re-establishment information and will notify the FSP program and the Impact Unit of authorization within two (2) business days.

g. If the appropriate Countywide Program Administration does not authorize the re-establishment, the denial is signed and forwarded to the appropriate Impact Unit. The denial is then forwarded to the FSP provider. Please note that this step does not apply for programs who receive direct authorization from appropriate Countywide Program Administration.

h. If the FSP agency does not agree with the decision of the Impact Unit or appropriate Countywide Program Administration, then the agency may file an appeal. (See III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment, or Transfer)

FORM:

- Full Service Partnership Reinstatement Authorization Form

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COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR HOUSING AND EMPLOYMENT	**IV.A.**	**11/1/2006**	**1 of 2**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish procedures to enable intensive services programs, such as Full Service Partnership (FSP), to work directly with potential landlords and employers on behalf of a client.

DEFINITION: Protected Health Information (PHI): PHI is defined in the Health Insurance Portability and Accountability Act (HIPAA) as "any health information, either oral or recorded in any form, that was created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse, that details past, present, or future physical, mental health, or the general health condition of an individual."

GUIDELINES: Prior to agency staff discussing/disclosing to any potential landlord and employer the fact that a client receives mental health services, it is necessary for the staff to 1) fully inform the client of the reasons for authorizing such disclosure, and the client's options with respect to this issue, and 2) obtain an Authorization for Use or Disclosure of Protected Health Information signed by the client.

These guidelines pertain to both the direct and indirect, (i.e., by virtue of the staff being employed by a mental health agency), revelation of a client's mental health status.

1. Prior to asking a client to sign the Authorization for Use or Disclosure of PHI, agency staff must:

    a. Inform the client of the way in which PHI would be used to advocate for employment and housing needs on the client's behalf, as well as the limitations of disclosure, (i.e., only relevant information and only to individuals who would assist the client with employment and housing issues).

    b. Inform the client that s/he has the option of withdrawing the authorization at any time. Once the client has been fully informed and agrees to the disclosure of PHI, agency staff must request that the client sign the Authorization for Use or Disclosure of PHI.

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR HOUSING AND EMPLOYMENT	**IV.A.**	**11/1/2006**	**2 of 2**
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2. Once a client has signed the authorization form, the agency staff may share relevant and necessary PHI with a potential landlord or employer. The case manager must exercise discretion in sharing PHI, sharing only the information necessary to obtain services for the client.

When a client refuses to sign (or once a client revokes an authorization), the case manager may not reveal PHI to prospective landlords or employers and should explain the implications of this restriction to the client.

FORMS:

- Authorization for Use or Disclosure of Protected Health Information (MH 602 Rev. 9/2016)

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SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
INTERRUPTION OF SERVICE DUE TO INSTITUTIONALIZATION	**IV.B.**	**5/11/2007**	**1 of 4**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish guidelines for making decisions about whether a participant in Full Service Partnership (FSP) should continue in the program while living in an institution, and to clarify billing and data issues for different institutional settings.

DEFINITION:

1. Interruption of service is defined as a temporary situation in which the client is expected to return to FSP services within twelve (12) months or less from the date of last contact.

2. Discontinuation of service is defined as a long-term situation in which the client is not expected to return to FSP services for more than twelve (12) months from the date of last contact.

3. Institution includes county or fee-for-service (FFS) acute hospitals; Institutions for Mental Disease (IMD); Enriched Residential/IMD Step Downs; Skilled Nursing Facilities (SNF); State Hospitals (SH); Psychiatric Health Facilities (PHF); Jail; Juvenile Hall; Probation camps; Department of Juvenile Justice (DOJJ); and Short Term Residential Treatment Program (STRTP).

GUIDELINES: During a client's stay in an institution, the agency must make a clinical determination about whether to keep the client actively enrolled in the intensive services program while living in the institution. All mental health treatment must be coordinated with, and permission granted by, institution staff if the intensive services program staff is going to enter the institution to continue providing services. All applicable claiming policies and procedures and data collection requirements must also be followed.

There are five categories of institutions that require special consideration upon entry of an intensive services program participant:

1. Incarceration in jail or prison, or detainment in Probation camp or CYA, that is anticipated to last less than ninety (90) days.

    a. The intensive services program should continue to provide services during the client's incarceration/ detention.

    b. A "residential" Key Event Change (KEC) must be entered for the client in the agency's Outcome Measures Application (OMA). (See V.A. Outcomes Data Collection or http://dmhoma.pbworks.com .)

c. For any services provided, the Medi-Cal box in the DMH Integrated System (IS/IBHIS) must be unchecked and Mental Health Services Act (MHSA) funds should be claimed.

2. Incarceration in jail or prison, or detainment in Probation camp or CYA, that is anticipated to last more than ninety (90) days.

    a. The intensive services program may discontinue providing services during the client's incarceration/ detention. A request for disenrollment should be submitted to the appropriate Impact Unit or Countywide Program Administration.

    b. A "discontinuation/interruption of community services" KEC must be entered for the client in the agency's OMA (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com).

    c. If/when the client is released from jail, prison, camp or CYA, the intensive services program is expected to prioritize the client for re-enrollment.

3. Admission to an IMD, State Hospital or Short Term Residential Treatment Program (STRTP) that has a contract with DMH for comprehensive mental health services.

    a. Upon admission, the intensive services program should file a request for disenrollment with the appropriate Impact Unit or Countywide Program Administration.

    b. A "discontinuation/interruption of community services" KEC must be entered for the client in the agency's OMA (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com).

    c. Any continued services and supports provided during the client's stay in the institution may not be claimed to Medi-Cal.

        i. Thirty (30) days prior to discharge from the institution, agencies may begin billing Medi-Cal for case management/discharge planning services.

d. If/when the client is released from the IMD, SH or STRTP, the intensive services program is expected to prioritize the client for re-enrollment.

4. Admission to a Skilled Nursing Facility.

   a. Upon admission to a SNF, a clinical determination must be made about whether to continue to provide services to the intensive services program participant.

   b. If the client continues to need mental health services, then he/she should remain enrolled in the intensive services program. A "residential" KEC must be entered for the client in the agency's OMA (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com).

      Medi-Cal can be billed for eligible services provided in the SNF by the intensive services program staff.

   c. If the client does not need ongoing mental health services, then services should be terminated and a "discontinuation/interruption of community services" KEC should be entered for the client in the agency's OMA (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com). A request for disenrollment should be submitted to the appropriate Impact Unit or Countywide Program Administration.

5. Admission to a Psychiatric Health Facility.

   a. Upon admission to a PHF, the client should remain enrolled in the intensive services program and the client episode in the IS should remain open.

   b. A "residential" KEC must be entered for the client in the agency's OMA (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com).

   c. For any services provided while the client is in the PHF, the Medi-Cal box in the IS must be unchecked and MHSA funds should be claimed. If this is not done, the PHF will be locked out from billing.

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REFERENCES:

- http://dmhoma.pbworks.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

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COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
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SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
TRANSFER OF CLIENTS BETWEEN FULL SERVICE PARTNERSHIP PROGRAMS	**IV.C.**	**11/1/2006**	**1 of 3**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish a procedure for the transfer of a Full Service Partnership (FSP) client from one FSP program/agency to another FSP program/agency including specialized FSP program/agency.

DEFINITION: A client may be transferred between FSP programs within the same agency, or between FSP agencies including specialized FSP agency, provided the new FSP program/agency has an available slot and agrees to the transfer. (Hereafter, the term "program" refers to transfers between programs within the same agency or between agencies.) The reasons for transfer are as follows:

1. Client requested a transfer.
2. Client has moved out of Service Area.
3. Client has moved within Service Area but closer to another FSP agency.
4. Client's linguistic/cultural needs.
5. Client aged out of current services.
6. Client will graduate or time out from Specialized FSP program.
7. Client's needs can be better served with a different type of program.
8. Other (provide explanation).

GUIDELINES: Transferring clients between FSP programs must be coordinated between the current program, the new/receiving program, and both the current Impact Unit(s) and the new/receiving Impact Unit(s). Countywide Program Administration must authorize all requests for client transfer from the current FSP program prior to an agency officially terminating services. The current FSP program should make reasonable efforts to ensure a successful transition for the client to the new FSP program, including providing services until a successful transition is achieved. The client's existing FSP program is not allowed to stop serving the client, nor is the client's existing FSP provider allowed to close the client's case until the transfer has been approved by countywide administration and the required documentation completed.

1. Upon determining that a client meets transfer criteria, current FSP program will complete Full Service Partnership Transfer

Request Form and submit to the age-appropriate Impact Unit Coordinator for pre-authorization of transfer.

2. Impact Unit Coordinator/Service Area Navigator will review transfer request within five (5) business days of receipt to determine appropriateness of transfer request and desired transfer location (if known).

    a. If client meets transfer criteria and is transferring within the Service Area, Impact Unit Coordinator/Service Area Navigator will identify appropriate new/receiving FSP program based on client need and slot availability. Impact Unit Coordinator/Service Area Navigator will forward Transfer Request to an appropriate new/receiving FSP program for screening and acceptance.

    b. If client meets transfer criteria and is moving out of the Service Area, the current Impact Unit Coordinator/Service Area Navigator will forward transfer request to new/receiving Impact Unit/Service Area Navigation for determination of FSP program options. When new/receiving FSP program has been identified, new/receiving Impact Unit/Service Area Navigation will forward Transfer Request to new/receiving FSP program for screening and acceptance.

    c. If Impact Unit Coordinator/Service Area Navigator determines that client does not meet transfer criteria, Impact Unit Coordinator/Service Area Navigator will complete and send Full Service Partnership Disenrollment/Transfer Request Supplemental Form to FSP program. FSP program must continue services.

3. If client is moving out of the Service Area, current Impact Unit/Service Area Navigator will forward the completed and signed Full Service Partnership Transfer Request Form to new/receiving Impact Unit/Service Area Navigator. New/ receiving Impact Unit/Service Area Navigator will pre-authorize client transfer and forward completed, signed Full Partnership Transfer Request Form to appropriate Countywide Program Administration for authorization. For Adult and Older Adult Impact Unit/Service Area Navigator don't need to sign Full Partnership Transfer Request Form when the transfer request was made though Service Request Tracking System, except Adult and Older Adult transfer will be requested via Full Partnership Transfer Request Form.

Current FSP program must continue services to client until Countywide Program staff has authorized enrollment of client to new/receiving FSP program.

4. Countywide Program staff will review request for transfer and pre-authorization information and will notify FSP programs and Impact Unit(s) /Service Area Navigator(s) of authorization for transfer within two (2) business days. Once transfer is authorized, current FSP program may close the case in the DMH Integrated System (IS) or may make the case inactive in the Integrated Behavioral Health Information System (IBHIS) and relevant Data Collection System (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com). If a client declines services after his or her case has been transferred from one Service Area to another, this client's file is still open and will remain open in the system until a disenrollment form has been completed and authorized by the Countywide Administrative Unit. It is the responsibility of the receiving provider to submit a request for inactive status via a signed disposition form by current provider or request via SRTS by current provider so that the client can be deemed inactive and the case can be closed even if no services were ever provided to the transferred client.

Important Notice: The only time a Disposition Form is used to close a case that was authorized, but never enrolled, is when no services were ever provided or billed by any FSP service provider.

5. The transferring FSP provider will complete an Outcome Measures Application (OMA) Key Event Change (KEC) that indicates the client's new provider site ID and will ensure all FSP outcomes are up to date and entered at the time of the transfer. If the client is transferring during a 3 Month Assessment window, the transferring agency will ensure it is completed.

6. The receiving FSP provider will do a KEC to indicate the client's new age group FSP program and update any relevant changes.

7. If appropriate Countywide Program Administration does not authorize client transfer they will complete and send Full Service Partnership Disenrollment /Transfer Request Supplemental Form to current FSP program and Impact Unit/Service Area Navigator. FSP program must continue services. If FSP agency does not agree with the decision of the Impact

   Unit/Service Area Navigator or appropriate Countywide Program Administration, then agency may file an appeal (see III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer).

FORMS:

- Full Service Partnership Transfer Request Form
- Full Service Partnership Disenrollment/Transfer Request Supplemental Form
- Disposition Form

REFERENCES:

- http://dmhoma.pbworks.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

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SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
FSP Services For Older Adults in Skilled Nursing Facilities	**IV.D.**	**7/1/2017**	**1 of 3**

PURPOSE: To provide guidelines for the delivery of FSP Services for older adults who reside in a Skilled Nursing Facility.

DEFINITIONS: 1. Skilled Nursing Facility (SNF) "A health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. It provides 24-hour inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services, and an activity program." (CCR, Title 22, Social Security, Division 5 – Licensing, Chapter 3 – Skilled Nursing Facilities.)

2. Skilled Nursing Facilities and other such facilities which are also Institutions of Mental Disease (IMD) " A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease/illnesses, including medical attention, nursing care, and related services." (Title 42, CFR, §435.1009(b)(2) and CCR, Title 9, Chapter 11, §1810.222.1)

GUIDELINES: SNF's that meets the federal definition for Institute for Mental Disease (IMD) cannot receive reimbursement from Medi-Cal for mental health services provided in an IMD unless it is for the purpose of discharge planning. Targeted Case Management services may be claimed in these facilities for up to three (3), thirty (30) non-consecutive days prior to discharge.

Individuals currently residing in a Non-IMD SNF and an FSP referral pending

1. Only those consumers who have a primary mental health diagnosis that is included under Medi-Cal for reimbursement are eligible for FSP.

2. DMH contracted and directly-operated programs that choose to provide services in a non-IMD SNF must develop an agreement

with the SNF to provide services on site.

3. DMH contracted and directly-operated programs must confer with the SNF's administration in advance of delivering mental health services to determine the type of mental health treatment services that are offered by the SNF to prevent duplication of services.

4. DMH contracted and directly-operated programs must work closely with the SNF's multi-disciplinary team to effectively plan treatment and to coordinate care.

5. DMH contracted and directly-operated programs must use the appropriate Service Location code when entering data. The correct Service Location Code is 31-Skilled Nursing Facility without STP.

6. DMH contracted and directly-operated programs are required to bill and collect all third-party revenue including Short-Doyle/Medi-Cal, Medicare, private insurance, other third-party revenue, and client fees.

7. DMH contracted and directly-operated programs must bill Medicare for mental health eligible services before seeking reimbursement from Medi-Cal.

<u>Consumers who are receiving FSP services and are transferred into a SNF</u>

1. DMH contracted and directly-operated programs who are providing FSP services to a consumer who is transferred into a non-IMD SNF may continue to provide FSP up to 60 days from the time of the admission into the SNF.

   DMH contracted and directly-operated programs must notify and seek approval from the Older Adult Impact administration within one (1) week of admission into a SNF in order to

continue to provide FSP services up to sixty (60) days from the date of admission to the SNF.

2. When a consumer resides in a non-IMD SNF for more than 60 days, DMH contracted and directly-operated programs must discontinue mental health treatment services and transfer the consumer's care to the SNF's clinical treatment team for on-going care. It is the expectation of DMH that a "warm hand-off" will be made by DMH or contract agency providers to ensure coordination of care in such transitions.

Older Adults being discharged from a SNF

1. A referral process will be established between the SNF and the DMH providers to identify potential referrals to FSP prior to the resident's discharge.

2. DMH contracted and directly-operated programs may seek approval for enrollment into FSP for a resident of a SNF 30 days prior to their discharge date.

REFERENCES: State Department of Mental Health Letter No. 02-06, "Medi-Cal Coverage for Beneficiaries in Institutions for Mental Disease"

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
SERVING CLIENTS IN RESIDENTIAL SETTINGS	**IV.E.**	**8/21/09**	**1 of 1**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish guidelines for collaborative working relationships between FSP programs and residential facilities housing FSP clients.

DEFINITION: Residential Services - Adults: Boards and Care, Transitional and long term Residential programs, Crisis Residential programs, Residential drug treatment programs, Skilled Nursing Facilities (SNF), Psychiatric Health Facilities (PHF) or other programs where clients live and are offered some level of mental health service.
Residential Services- Children: Rate Classification Level (RCL) 11 and below group homes. Individuals residing in and receiving treatment from Short Term Residential Treatment Program (STRTP) are not eligible for FSP services without countywide pre-approval.

GUIDELINES: FSP programs are responsible for providing a culturally and linguistically appropriate array of mental health services as defined in LAC-DMH RFS 1 or 2. The FSP team assumes the responsibilities documented in LAC-DMH policy 202.31. The FSP program assumes overall responsibility for care coordination, including determining with the client/family the role of the residential program in providing services to the client.

1. Care should be coordinated in order to maximize quality of care and avoid service duplication.

2. Within program guidelines, client choice should be a key factor in care coordination efforts with residential programs.

3. For each FSP client living in a residential care program, services should be tailored to the needs and wishes of the client. The FSP program should involve the family when appropriate, in conjunction with the residential program, shall outline service responsibilities in the Client Treatment Plan.

4. The FSP team should meet regularly with residential treatment staff to review services and the client's response to treatment and should modify treatment plans accordingly.

5. Medication services should be provided by the FSP psychiatrist, with limited exceptions.

6. California Code of Regulations, Title 9, Division 1, Section 532 specifies the service requirements for residents of Long-Term Residential Treatment Programs.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
OUTCOMES DATA COLLECTION	**V.A.**	**11/1/2006**	**1 of 1**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish a procedure to collect Full Service Partnership (FSP) client outcomes data using the DMH Outcome Measures Application.

DEFINITION: Outcome Measures Application (OMA): An electronic web-based application for collecting, tracking and reporting outcome data for clients enrolled in FSP programs.

Partnership: A client's enrollment in FSP is considered a partnership. It begins with their first approved service in any FSP program and continues until disenrolled. If a client disenrolls from FSP and returns within 1 year, the client reestablishes their previous partnership. If the client has been disenrolled for more than 365 days and then returns, a new partnership will be established.

GUIDELINES: All FSP agencies must complete a Baseline Assessment, report Key Event Changes as they occur, and complete 3-Month Quarterly Assessments for all enrolled FSP clients.

1. A Baseline Assessment must be completed and entered into the OMA within thirty (30) days of the Partnership date. A client has only one baseline created for each partnership. The only exception to this is if a client is restarting a Partnership more than twelve (12) months after discontinuation/disenrollment from a FSP program. The baseline completed is based on the age of the client on the partnership date. If the client is 0-15 when partnership starts a Child baseline is completed, if 16-25 a TAY baseline, if 26-59 an adult baseline and an older adult one if age 60 or older.

2. A Key Event Change (KEC) must be completed each time the agency is reporting a change in status in certain categories. These categories include residential status, employment, education, crisis/PMRT, and benefits establishment. Complete only the section pertaining to the reported change.

3. If a client is being transferred from one type of FSP program and/or one FSP agency/provider to another, is disenrolled, or the Partnership is being restarted after less than 12 months from an interruption/discontinuation, this must be reported in a KEC. Please ensure all changes are up to date before filing transfer or disenrollment KEC.

4. If a client is reestablishing a previous partnership due to being disenrolled for less than 365 from any FSP, a reestablishment

KEC must be completed. Status changes that occurred while the client was away from partnership need to be reported in separate KECs, (i.e, residential changes, hospitalizations, crisis or emergency response, changes in employment or education).

5. 3-Month Assessments (3M) should be completed around every 3-month anniversary of the Partnership date. Agencies have a window of fifteen (15) days prior to the 3M due date to thirty (30) days after the anniversary date to complete the assessment. If the 3M assessment cannot be completed within this forty-five (45)-day window, it should be skipped altogether and completed when the next one is due. Keep in mind that the partnership date and 3M due dates are established at the inception of the partnership. If the client passes through multiple providers and multiple FSP programs without being disenrolled for 365 days, the partnership date and 3M due dates of the original provider are retained.

FORMS:

- Outcome Measures Application Baseline Assessment, Key Event Change, and 3M Quarterly Assessment for Children, Transition-age Youth (TAY), Adults, and Older Adults (3 forms for each age group)

REFERENCES:

- http://dmhoma.pbworks.com (Outcome Measures Application (OMA) Project website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
DISENROLLMENT GUIDELINES	**VI.**	**11/1/2006**	**1 of 3**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish a procedure for the disenrollment of a Full Service Partnership (FSP) client from a FSP program.

DEFINITION: Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact. A discontinuation of service is defined as a long-term situation in which the client is not expected to return to FSP services for more than twelve (12) months from the date of last contact. The reasons for disenrollment are as follows:

1. Target population criteria are not met. Client is found not to meet target population; in most cases, clients who are discovered to have no major mental illness or serious emotional disturbance (SED).

2. Client decided to discontinue Full Service Partnership participation after partnership established. Client has either withdrawn consent, refused services after enrolling, or no longer wishes to participate in FSP.

3. Client moved to another county/service area. Client relocated to a geographic area either outside or within L.A. County, and will not be receiving FSP services of any type anywhere in Los Angeles County.

4. After repeated attempts to contact client, client cannot be located. Client is missing, has not made contact with FSP agency. Agency may request disenrollment of a client after multiple documented outreach attempts for at least thirty (30) days but not more than ninety (90) days.

5. Community services/program interrupted – Client's circumstances reflect a need for residential/institutional mental health services at this time (such as, an Institute for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC) or State Hospital (SH). Client is admitted to an IMD, MHRC or SH.

6. Community services/program interrupted – Client will be detained in juvenile hall or will be serving camp/ranch/

DOJJ/jail/prison sentence. Client is anticipated to remain in one of these facilities for over ninety (90) days.

7. Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropriate. Client has successfully met his/her goals, as demonstrated by involvement in meaningful activities, such as, employment, education, volunteerism or other social activities and is living in the least restrictive environment possible, such as an apartment. The client no longer needs intensive services and is ready to receive services at a lower level of care.

8. Client is deceased. This includes clients who died from either natural or unnatural causes after their date of enrollment.

GUIDELINES: Countywide Program Administration must authorize all requests for client disenrollment from the FSP program prior to an agency officially terminating services.

1. Upon determining that a client meets disenrollment criteria, the FSP agency will complete the Full Service Partnership Disenrollment Request Form and submit it to the age-appropriate Impact Unit Coordinator for pre-authorization of disenrollment.

2. Impact Unit Coordinator will review the disenrollment request within five (5) business days of receipt. Clients that meet FSP disenrollment criteria will be pre-authorized and forwarded to Countywide Program Administration. For clients that do not meet disenrollment criteria, Impact Unit Coordinator will complete and send Full Service Partnership Disenrollment/ Transfer Request Supplemental Form to FSP program. FSP program must continue services.

3. Countywide Program Administration staff will review the request for disenrollment and pre-authorization information and will notify the FSP program and Impact Unit of authorization for disenrollment within two (2) business days. Once disenrollment is authorized, the FSP program can stop serving the client and provider needs to ensure all outcomes are entered prior to filing a discontinuation Key Event Change with the authorized

disenrollment reason indicated in the Outcome Measurement Application. (see V.A. Outcomes Data Collection or http://dmhoma.pbworks.com).

If Countywide Program Administration staff does not authorize client for disenrollment they will complete and send Full Service Partnership Disenrollment /Transfer Request Supplemental Form to FSP program and Impact Unit. FSP program must continue services.

4. If FSP agency does not agree with the decision of the Impact Unit or Countywide Program Administration, then agency may file an appeal (see III.C. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer).

A client transferring from one FSP program to another FSP program is not considered a disenrollment (see V.C. Transfer of Clients Between Full Service Partnership Programs).

FORMS:

- Full Service Partnership Disenrollment Request Form
- Full Service Partnership Disenrollment/Transfer Request Supplemental Form

REFERENCES:

- http://dmhoma.pbworks.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
24/7 CRISIS COVERAGE	**VII.**	**3/20/2007**	**1 of 3**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish a procedure for 24/7 crisis response FSP programs

DEFINITION: Crisis coverage: An on-call and in-person response system that includes LPS-designated staff to address clients in crisis 24 hours a day, 7 days a week (during and after regular program hours, and on weekends and holidays).

GUIDELINES: Per California Code of Regulations, Title 9, Div. 1, Chapter 14 (MHSA regulations), in the event of an emergency a personal services coordinator, case manager or other qualified individual known to the client/family must respond to the client/family 24 hours a day, 7 days a week to provide during and after-hours intervention.

1. Each FSP program must have LPS-authorized staff available to respond to a client in crisis for the purpose of evaluation and initiation of a 5150/5585.

2. In the event ACCESS received a call from a client, ACCESS will link the client to the FSP program for response. The FSP program must respond to the request for assistance and ensure that the client's needs are addressed, either on the telephone or in-person depending upon the FSP staff's assessment. In the event the staff responding does not have LPS authorization, the staff should have access to contact a LPS authorized staff to assist if an evaluation for an involuntary hold is needed. As a last resort, if no LPS authorized staff is available, the provider can request assistance from ACCESS.

3. The Department of Health Services (DHS) and DMH have a centralized procedure for admission of indigent clients that are evaluated in **non-hospital community settings** by DMH Directly Operated facilities and LPS designated contracted out-patient programs. If the client meets 5150/5585 criteria, provider will:

   a. Call DHS Central Dispatch Office (CDO) (formerly called Medical Alert Center – MAC) (866) 941-4401 to request destination assignment for the client.

   b. Provide CDO with the following information:
      - Your Service Provider, e.g., PMRT, MET, HOPE, Downtown MHC, etc.
      - Your name
      - Client's name

- City/location of the client
- CDO operator will provide you with a call reference number and also provide the name of the County hospital ER or another facility assigned to receive the client.
- Call ACCESS 1-800-854-7771 to request ambulance with an accepting physician name.
- Document CDO (MAC) call reference number on the front of a sealed envelope containing the 5150/5585 application.

c. Call County hospital ER or other facility assigned by CDO and advise: "Per CDO, we are sending (client's name) to your ER. Estimated time of arrival is approximately (hrs/min)." Provide County hospital ER with brief report regarding client.

d. Clinician must not leave the scene until the ambulance transports client. Call ACCESS to provide ambulance arrival and departure time.

e. If you encounter any problems with CDO, contact Robert Moore, CDO supervisor at (213) 590-3322 (cell) or (562) 347-1701 (office). If your concern is not resolved, contact your manager.

4. Providers evaluating indigent clients for 5150/5585 in **private hospital medical emergency rooms (Non-LPS Designated)** shall address the following:

- Client should be medically cleared and medically stabilized for transfer as defined under Emergency Medical Treatment and Active Labor Act (EMTALA). FSP provider determines that client meets 5150/5585 criteria for involuntary detention.
- Private hospital medical emergency room physicians contacts the nearest open DHS PED, speaks directly to the physician to present the transfer and to negotiate the transfer acceptance.
- If accepted, the private general medical emergency room arranges transfer.
- When all DHS PEDs are on diversion, or when a transfer is denied, the provider instructs the private general medical emergency room to contact the nearest DHS PED to negotiate the transfer acceptance based on DHS PED capacity until the client is accepted or until other circumstances arise.

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
24/7 CRISIS COVERAGE	**VII.**	**3/20/2007**	**3 of 3**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

- When accepted, the sending physician makes the transportation arrangements.
- FSP provider who completes the 5150/5585 hold must communicate daily with the private general medical emergency room in order to monitor the client transfer status.

ATTACHMENT:
- LPS Designated Facilities

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Antelope Valley Hospital 1600 West Avenue J Lancaster, CA 93534 (661) 949-5000 Ownership: Community (AV Healthcare District) District #5	1	1	Michael Wall, CEO 1'17 Ayako Smith, CNO 4'17 (661) 949-5000 JoAnn Minor- Dir.-MHS 6'15 (661) 949-5255; 951-4445 FAX Vikki Haley-Compliance (661) 949-5590; 951-4284 FAX (661) 949-5238 MHU FAX (661) 949-5250 MH Unit	FC	14 (12 in use; lic. for 30 beds)	GACH
Aurora Charter Oak Hospital* 1161 E. Covina Blvd. Covina, CA 91724 (626) 966-1632 Ownership: Signature HealthCare-Su Kim, MD District #5	1,2,3	3	Todd Smith, CEO (626) 859-5299 Sheila Cordova, COO (626) 859-5236 QI Dir. 859-5297 (626) 859-5292 FAX	FC	134 (104 Adlt., 30 Adol.) (39 lic 10/2012) [12 CD res]	APH
Aurora Las Encinas Hospital* 2900 E. Del Mar Blvd. Pasadena, CA 91107 (626) 795-9901 Ownership: Signature HealthCare - Su Kim, MD District #5	1	3	Thomas Mahle, CEO 1'17 (626) 356-2653 (626) 356-2622 FAX Ariane Loera, Exec. Asst -2650 Jennifer Fricke, Int. CNO x2738 1'17 Brent Bowers-Strategic Plng.-Bus. Dev. (626) 356-2663 (626) 356-2704 Nsg.Superv.	FC	118 (96 in use; 22 CD) [Pending new bldg.. 12'18) [30 RTC]	APH
BHC Alhambra Hospital* 4619 N. Rosemead Blvd. Rosemead, CA 91770 Ownership: Universal Health Services District #1	1,2,3	3	Peggy Minnick, CEO (626) 286-1191, x232 (626) 286-2489 FAX Vicki Gant, DON x266 12'13 Rob Vandesteeg, PhD-PI-x238 Intake x268	FC	97 (eff. 3/2009) (65 Adlt., 32 Ch./ Adol.)	APH
Bellflower Medical Center - [See **Non-Designated Facilities-L.A. Community Hospital at Bellflower**]	1	7	**Sold** 5/2/2014 **to Alta/LACH)** (**re-opened** as **Vol. hosp. 7/2015-**LACH@B)	FC	32 [BH **closed** 4'13]	GACH [5'13-Lic. **suspended**]
Brotman Medical Center –[See **Southern California Hospital at Culver City**-See **Non-Designated Facilities**]			**Merged** with HCH 1/1/2013; **new name** 11/7/13			
Cedars–Sinai Medical Center/Thalians -- See **Non-Designated Facilities**			**Psych. closed 3/9/12** (vol.) No Invol. after 11-30-10			
Citrus Valley Medical Center/ Inter-Community Campus 210 W. San Bernardino Rd. Covina, CA 91723 Ownership: Citrus Valley Health Partners District #5	1	3	Robert Curry, CEO (626) 331-7331 Karen Knueven, CNE 12'14 (626) 938-7600 Stacey Hill- Prog. Dir. 7'13 Parkside West (MHU) (626) 938-7647 (626) 938-7650 MHU (626) 859-5848 FAX	FC	30	GACH
College Hospital* 10802 College Place Cerritos, CA 90703 Ownership: College Health Enterprises (Barry Weiss) District #4	1,2	7	Steve Witt, CEO (562) 924-9581 x268 (562) 924-6523 FAX Louise Ferraro-Assoc Admn (562) 293-0521 x259 Kiyo Teshima, CNO x222 Cara Jenson-QI/RM x307 Intake x514	FC	187 (161 Adlt., 26 Adol.; 11'16 on, vs. 42 Adol.) [30 beds lic 3'12]	APH

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
College Medical Center* (**form.** Pacific Hospital of Long Beach) 2776 Pacific Avenue Long Beach, CA 90806 (562) 997-2500 College Medical Center- South Campus 1725 Pacific Ave. Long Beach, CA 90806 (562) 256-8400 College Medical Center- Hawthorne Campus 13300 S. Hawthorne Boulevard Hawthorne, CA 90250 [purchased 7/2014] Ownership: College Health Enterprises 10/2013 District #4; District #2- Hawthorne	1,4 1 1	8 8 8	Joe Avelino, CEO (10/**8**/13) (562) 997-2402; -2411 (562) 492-1363 FAX Tammy Jo Somesta, CNO 4'16 (562) 997-2277 (8/2013) (562) 997-2276 FAX Ava Gillett- Dir-BHS (10'13) (562) 997-2501; (323)781-5057cl (562) 997-2519 FAX South Campus: (562) 265-8400 Courtney Harrison, Nsg. Mgr. (562) 256-8351 Psych. Units x1314, x1251 Hawthorne Campus: Tim Youngerman-Nsg Sup-3022 (424) 365-3000	FC	137 (37 Main-20 Adlt., 17 Gero.) (South- 36 Adlt.) (H-64 Adlt. Lic. 11'15, d.11/30/15; open 1/6/16)	GACH
Community Hospital Long Beach* 1720 Termino Avenue Long Beach, CA 90804 (562) 498-1000 Ownership: MemorialCare Health System District #4	1	8	Laura Lundquist-Int. Admin. (562) 498-0634 (5'15) (562) 498-4434 FAX Sheryl Howland-Exec. Dir., Pt. Care Svcs (562) 494-9403 Patricia Sanchez-BH Mgr. 6'16 (562) 494-9329 (562) 494-0790 FAX (562) 494-0581 (BH Unit)	FC	28	GACH
Correctional Treatment Center- Mental Health Unit Twin Towers-Medical Services Bldg., 4 East 450 Bauchet Street, Room M4127 Los Angeles, CA 90012 [**formerly** Forensic Inpatient Program (FIP)] Ownership: County District #1	1	4	J. Neil Ortego, MD-Acting Dir., Jail MH Svcs/Chief Psychiatrist Tim Belavich, PhD- DHS M.Hlth. Prog. Mgr. (213) 974-9083 Supervising Psychiatrist (213) 893-5397 (213) 217-4855 FAX Cheryl Vander Zaag, PhD (213) 893-5417 Mimi Hanzel, PhD 893-5431 Justiniano Jaojoco, Nsg.-5406 (213) 893-5392 MHU	C	43 (+3 vol. non-desig. beds) total lic.-46	CTC (Licensed as: Mental Health Unit of Correctional Treatment Center)
Del Amo Hospital* 23700 Camino Del Sol Torrance, CA 90505 (310) 534-0473 Ownership: Universal Health Services District #4	1,2,3	8	Lisa Montes, CEO 7'17 (310) 530-1151 x201 (1'15) (310) 534-0473 FAX Tina Clark, Asst. Admin. x279 (310) 784-2279; DON-2220 Dena Nishimura, DON (4/12) (800) 533-5266 Units-Youth/ NTC-ED/CRU/Del Sol/TCU/ITU	FC	166 (120 Adlt., 14 Ch., 32 Adol.) [4/2014]	APH
Dignity Health Northridge Hospital Medical Center 18300 Roscoe Blvd. Northridge, CA 91328 Ownership: Dignity Health District #3	1,2, (5)	2	Saliba Salo, Pres./CEO (9/12) (818) 885-8500, x2926 (818) 885-5439 FAX Mary Jane Jones, CNE Mayte Eriksson, BHS Dir. (818) 885-8500 x3621 (818) 885-3584 FAX Yaw Daaku, Clin. Mgr. x2317 (818) 885-5484 Crisis Team (818) 885-5326 East Pav. (818) 885-3742 West Pav.	P	40 (31 Adlt., 9 Adol.) [Gen. Adlt.-19 beds; ITU-12 beds]	GACH

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
East Valley Hospital Medical Center – See **Glendora Community Hospital**			[**new owner** 5/21/2014]			
Encino Hospital Medical Center* 16237 Ventura Blvd. Encino, CA 91436 (818) 995-5000 Ownership: Prime Healthcare (Prem Reddy, MD) (5/08) District #3	4	2	Bockhi Park, CEO (8'12) (818) 995-5000, x5008 (818) 581-1664 Em Garcia, Admin. (5'13) (818) 205-1997 Vilma Dinham, CNO Wayne Hoo- Dir.-Psych. Svcs. (818) 907-2847; 995-5051 5'17 (818) 907-4534; 995-5459 FAX (818) 995-5174 (Gero. Unit)	P	13 (gero) [dropped '16 plan to add 26 beds]	GACH
Exodus Recovery Psychiatric Health Facility 9808 Venice Boulevard, 3rd Floor Culver City, CA 90232 Exodus Recovery, Inc. 9808 Venice Boulevard, Suite 700 Culver City, CA 90232 Ownership: (Mgt.: Exodus Recovery, Inc) District #2	1	5	Kathy Shoemaker, Admin. (310) 945-3352; 966-0694-cell Connie Dinh, VP-Nsg. (310) 237-0454 x131 (310) 237-0474 FAX Robert Dutile, PhD, Prog. Dir. x127 3'16 (310) 237-0454 PHF	CGF	16 [lic. 12/10/13; d. 1/8/14; open 1/15/14]	PHF
Exodus Recovery Urgent Care Center - Eastside 1920 Marengo Street Los Angeles, CA 90033 Ownership: (Mgt.: Exodus Recovery, Inc.) District #1	1,2 (age 16+)	4	Luana Murphy, Pres./CEO (310) 945-3350 Kathy Shoemaker, Admin. (310) 945-3352 (310) 840-7023 FAX Connie Dinh, Dir. of Nsg. (323) 276-6488 Rex Manuel-Prog. Dir. -6488 (323) 276-6400 EUCC (323) 276-6499 FAX	MHSA	16 Convertible chairs - 10 Adlt., 6 TAY (d. 4/28/10) (+6 DCSF minors 2/28/11)	Not Licensed
Exodus Recovery Urgent Care Center Westside 11444 West Washington Boulevard, Suite D Los Angeles, CA 90066 Ownership: (Mgt.: Exodus Recovery, Inc.) District #2	1	5	Luana Murphy, Pres./CEO (310) 945-3350 Kathy Shoemaker-Sr. VP/ Admin (310) 945-3352 (310) 840-7023 FAX Connie Dinh, VP-Nsg. Tim Vu, Prog. Dir. (310) 253-9494 WUCC (310) 253-9495 FAX	MHSA	12 conv. chairs d./open 12/14/15	Not Licensed
Exodus (MLK) – See **Mental Health Urgent Care at MLK by Exodus**						
Gateways Hospital & M.H. Center 1891 Effie Street Los Angeles, CA 90026 Ownership: Gateways District #1	1,2	4	Philip Wong, Interim CEO (323) 644-2000 x274 5'17 (323) 913-9037 FAX Philip Wong, COO x222 Fely Navarra-Int. CNO x258 7'15 (323) 666-1417 FAX Suzanne Gill, QI Dir. 10'13 Sara Garza, Nsg. Mgr. x258 Units: Adol. x303; North x305	CGF	55 (28 Adlt., 27 Adol.)	APH
Glendale Adventist Medical Center 1509 Wilson Terrace Glendale, CA 91206 (818) 409-8000; [New name pending 7'17- Adventist Health Glendale] Ownership: Adventist Health District #5	1 (5)	2	Kevin Roberts, CEO Karen Brandt-Mayo, CNO Scott Robertson-Beh.Med Dir (818) 409-8407; -8027 4'14 (818) 956-7687 FAX BH Mgrs: Joanne Lopez-PIC, Lazarro Meno-PAC (818) 409-8063 P1West (818) 409-8065 P2; P1E-8038	FC	60	GACH

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Glendale Memorial Hospital and Health Center* 1420 South Central Avenue Glendale, CA 91204 (818) 502-1900 Ownership: Dignity Health BHU Mgt.: Horizon Health (Universal Hlth. Svcs.) District #5	1	2	Jack Ivie, Pres./CEO 'til **6/30**/17 (818) 502-2201 Flordeliza Abcede, VP Pt. Care Svcs/CNE (818) 502-2347 Dominique Holmes-Int. BH Mgr. (818) 502-4760 6'17 (818) 409-5258; -502-4558 FAX Nsg. Mgr - Unit Sec.- Sara Ramirez (818) 502-2362 3 South		30 [lic./open 9/2013; LPS design. 12/2013]	GACH
Glendora Community Hospital [5/22/14] [**formerly** East Valley Hospital Medical Center] 150 West Route 66 Glendora, CA 91740-6307 (626) 852-5000 Ownership: Prime Healthcare Services, Inc. (Prem Reddy, MD) [**new owner 5/21/14**] District #5	4	3	Sofia Abrina, CEO 11'15 (626) 852-6125; -5099 FAX Mary Ann Bennett, CNO (626) 852-5010; -5012 FAX Dir.- Sr. MH- 4'17 (626) 852-6121 (626) 963-6843 FAX (626) 852-5063 Sr. MH Unit	P	21 (gero) (24-30 bed Gero. addit. by **8/2018**)	GACH
Harbor-UCLA Medical Center 1000 W. Carson St Torrance, CA 90509 (310) 222-2345 (310) 222-2383 Info. Desk Ownership: County of Los Angeles District #2	1	8	Kim McKenzie, CEO (310) 222-2135 7'15 Pattie Soltero-Interim CNO (310) 222-3401 (Mailbox #1) Kimmalo Wright, Acting Clin. Dir.–BH, x1747; (310) 222-1747 (310) 222-3394 (Pat Venaglia) (310) 212-7609 FAX Ira Lesser, MD- Chair, Dept. of Psychiatry (310) 222-3101 Debbie Rhodes, Nsg. Mgr. (310) 222-4090 Office-PER (310) 222-3114 8W (310) 222-3291 -1 South/CRU	C	38 (8W- 24 beds; 1So./CRU- 14 beds) [+19 bed PER]	GACH
Harbor View Adolescent Center [See **IMDs-** Harbor View Behav. Health Center] 490 West 14th Street Long Beach, CA 90813 (562) 591-8701 Ownership: Genesis Healthcare Group District #4	2	8	Wendy McLearie-Admin.10'14 (562) 591-8701, x240 (562) 591-0235 FAX Saham Plong, DON x242 (562) 591-9851 FAX Maria Pedraza, HIM x262 (562) 591-8701, x223 Nsg. Sta.	CGF	39 Adol. **closed** 7'14 -opened as **Adult IMD 1/13/2015**	SNF
Henry Mayo Newhall Hospital [**name change** 4/2014] 23845 W. McBean Parkway Valencia, CA 91355 (661) 253-8000 [BHU- 25727 N. McBean Parkway] Ownership: Community District #5	1	2	Roger E. Seaver, CEO Larry Kidd, CNO (661) 253-8753 (661) 253-8142 FAX Grace Watford, Dir.-BHU (661) 253-8979 (661) 253-8932 FAX Cary Quashen, Exec. Dir. (661) 713-3006 Michael Perez, Clin. Coord. (661) 253-8953; -8932 FAX (661) 253-8954 BHU (661) 253-8932 BHU FAX	P	23	GACH
Hollywood Community Hospital at Brotman Medical Center –See **Non-Designated Facilities- Southern California Hospital at Culver City**-			[**new name** 11/7/13]			

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

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Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Huntington Hospital Della Martin Center for Beh. Hlth. Svcs. 100 W. California Blvd. Pasadena, CA 91105 HH (626) 397-5000 DMC (626) 397-2324 Ownership: Huntington Memorial District #5	1,4 (5) (14 Gero.)	3	Stephen Ralph, Pres./CEO Gloria Sanchez-Rico, VP Pt. Care Svcs. (626) 397-3664 Alison Birnie, Clinical Dir. BHS (626) 397-5105; -2313 (626) 397-2922 FAX; -2981 Della Martin Center- Nsg. Mgrs.: Alison Birnie, Int. Nsg. Mgr. (626) 397-2318; -2339 (626) 397-2304 Unit 400	FC	50 (38 in use) (U 400- 12 beds/10 in use; U 200-14 gero; U 100- 12 vol.-ECT); [+U 300-12 beds-CD]	GACH
Kaiser Permanente Mental Health Center* 765 W. College Street Los Angeles, CA 90012 (213) 580-7200 William Grice, Executive Director Kaiser Permanente Los Angeles Medical Center 4867 W. Sunset Boulevard Los Angeles, CA 90027 (323) 783-4011 4841 Hollywood Boulevard (Admin. 738-8100) Ownership: Kaiser District #1	1	4	James E Moore, MD, Med Dir. (213) 580-7322, -7310 Theresa M Berkin- Clin. Hosp. Dir. (213) 580-7324; -7241 FAX Maricel Santos-Actg DON x7242 Sharon Peters-Asst Med Ctr Adm (323) 783-8105; KPLAMC-8100 Patricia Claussen-CNE-KPLAMC (PET) (800) 900-3277 Nsg. Supervisor (213) 580-7345 (213) 580-7292 Stn 1 (213) 580-7219 Stn 2; Stn 3(G)	P	68	GACH
Keck Hospital of USC **(form.** USC Univers. Hosp.- **name change** 11'11) 1500 San Pablo Street Los Angeles, CA 90033 Ownership: Univ. of Southern Calif. [4'09] District #1	(5) (6) [still doing ECT, also DBS]	4	Scott Evans, CEO (323) 442-8656; 442-8444 Tom Jackiewicz-VP USC Hlth Annette Sy, CNO 442-8555 (800) 872-2273; 700-5700	P	10 (**BHU closed 11/1/13**)	GACH
Kedren Acute Psychiatric Hospital & CMHC 4211 S. Avalon Blvd. Los Angeles, CA 90011 Ownership: Kedren Community Health Center, Inc. District #2	1,3	6	John Griffith, PhD-Pres/CEO Asha Zawadi, Acting CNO (323) 233-0425 11'16 (323) 233-6483 FAX x130 x131, x136- CIP x301 x302 x309- AIP	CGF	72 (55 Adlt., 17 Child-ages 5-12)	APH
LAC+ USC Healthcare Network Inpatient Clinical Tower- Administration 1200 N. State St., Suite C2K100 Los Angeles, CA 90033 LAC+USC Medical Center 2051 Marengo Street Los Angeles, CA 90033 [ER/PER: 1983 Marengo Street, L.A. 90033] (323) 409-1000 Ownership: County District #1 LAC+USC HCN (AF Hawkins Bldg.-2nd fl.) 1720 E. 120th Street Los Angeles, CA 90059 LAC+USC @ AFH– Ward F (11-minors) LAC+USC @AFH: A-12, B-14, C-12, D-12, E-9 (G-6; not in budget) (licensed beds) Ownership: County DHS District #2	1 (5) 1,2	4 6	Donna Nagaoka, Int. CEO (323) 409-2800, -2622 6'17 Marisa Cordova, Executive Admin.-Psych. (all sites) (8'16) (323) 409-2809, 409-2800 (323) 441-8030 FAX Steven Siegel, MD-Psych Chair (all sites); (323) 442-4000 CSC Bldg. -4065 (Sec.-Gracie) Isabel Milan, CNO; 409-6747 Annie Marquez, DON (323) 409-5605 (all sites) Tim Botello, MD-Med.Dir. Adlts. (424) 338-2500 Medical Admin. Olga Green, Nsg. Mgr. 338-2556 (424) 338-2555 AFH-Nsg.Off. (310) 631-7419 FAX (424) 338-2564 A-AFH (424) 338-2567 B-AFH (424) 338-2570 C-AFH (424) 338-2573 D-AFH (424) 338-2575 E-AFH (424) 338-2577 F-AFH 1st fl. - G-AFH	C C	76 lic. psych. [at AFH] Med. Ctr. [24 Medi-Psych (2 E) & 12 PER] AFH (12 Adol. + 64 Adlt. = **76 Lic.** beds) [11 Adol. + 51 Adlt. = **62 beds** in use]	GACH GACH-AFH campus

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

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Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
LAC+ USC @ Ingleside [East (24 beds-**closed** 7/2010); Center (16 beds-**closed** 8/2008)]			LAC+USC @ Ingleside (**closed** 7/2010)			
La Casa Psychiatric Health Facility 6060 Paramount Blvd. Long Beach, CA 90805 Ownership: Telecare Corp. District #4	1	8	Tiffany Jump, Administrator (562) 630-8672, x418 (562) 529-24638354 FAX David Heffron, VP Ops x143 Shannon Legere, Reg. Dir. 10'16 Apisak (Mike) Intalapitagsa-DON x113 (562) 630-8672 (PHF Unit)	CGF	16	PHF
L.A. Metropolitan Medical Center 2231 S. Western Ave. Los Angeles, CA 90018 L.A. Metropolitan Med. Center* - Hawthorne 13300 S. Hawthorne Blvd. Hawthorne, CA 90250 [**H-sold to College 7/9/14**] Ownership: Pacific Health Corp. District #2	4 1	6 8	CEO (323) 730-7342 CNO - (323) 730-7300, x342 DON x206 (Western) (323) 730-7300 x771 (Unit) DON- Adult (310) 679-3321 x303 (H) (310) 676-9018 FAX Unit 1 x293; Unit 2 x331	FC FC	98 total [**BH closed 4/10/13**] (34-W) (**64-H**)	GACH [Lic. in suspense **May 2013**]
Los Angeles Jewish Home For The Aging***** Auerbach Geriatric Psychiatric Unit 7150 Tampa Avenue Reseda, CA 91335 Joyce Eisenberg Keefer Medical Center 7150 Tampa Avenue Reseda, CA 91335 Ownership: Los Angeles Jewish Home For The Aging District #3	4	2	Mary M. Forrest-CEO-LAJHA (818) 774-3208 (818) 774-2426 FAX Larissa Stepanians, COO (818) 774-3371 Auerbach Geri. Psych. Unit Phyllis Metz, Prog. Dir. 4'16 (818) 758-5045 (818) 757-4456 FAX SS Dir. Janice Gershon -5038 Ilana Grossman-CEO-x3069 Joyce Eisenberg Keefer Med. Ctr. Jerry Wahagheghe, DON (818) 774-3211 (818) 758-5041; -5042 GP Unit	P-Medicare	10 (gero) (**pending 14 bed expansion 2017**)	APH
Mental Health Urgent Care at MLK by Exodus 12021 Wilmington Avenue Los Angeles, CA 90059 Ownership: County DHS (Mgt.: Exodus Recovery, Inc.) District #2	1,2 (ages 12+)	6	Kathy Shoemaker, Admin. (310) 945-3352 (310) 840-7023 FAX Connie Dinh, Dir. of Nsg. Jan Toler, Prog. Dir. (562) 295-4617 MH UC-MLK (562) 295-4665 FAX	MHSA	22 Convertible chairs - 16 Adlt., 6 Adol. (**d./open 9/4/14**)	Not Licensed
DSH – Metropolitan LA (**current name**) [Metropolitan State Hospital- **former** name] 11401 Bloomfield Ave. Norwalk, CA 90650 Ownership: State District #4	1 [Ch/Adol. 48 beds **Closed** 12/31/07]	7	Michael Garsom, Exec. Dir. 5/12 (562) 863-7011, Ext. 2245 Karen Chong, Acting Clin. Admn (562) 651-4321 Mike Nunley, Compliance (562) 651-2215 or -2214	State Operated	274 Adlt **4-28-08-Design. not renewed by LA Cty**	APH
Mission Community Hospital* 14850 Roscoe Blvd. Panorama City, CA 91402 (818) 787-2222 Ownership: Deanco Healthcare, LLC District #3	1	2	Jim Theiring, CEO (818) 904-3652 (818) 904-3529 FAX Dianne Wagner, COO/CNO (818) 904-3685; 904-3596 FAX Vincenzo Variale-CFO/VPBHS Soc. Svcs. (818) 904-3116 Renee Ruiz-Assoc. Dir.BHS (818) 904-3105 Rhonda Delao, Nsg. Mgr.-3122 (818) 904-3104 North (818) 904-3101 South	FC	60 (pending 7 chair PER Obs. Unit)	GACH

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

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Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Motion Picture & Television Fund Hospital 23388 Mulholland Drive Woodland Hills, CA 91362 (818) 876-1888 Ownership: Motion Picture & TV Fund District #3	4	2	Robert Beitcher-Pres/CEO-4155 Shirley Heidersbach Admin. Sharon Seifert-VP-Legal Affairs (818) 876-1775; -1541 Joanne Hoopes, DON/BH Dir. (818) 876-1478; 876-1556 FAX (818) 876-1250 Gero Unit	P	12 Gero. (lic. 2/23/15; d. 9/12/16)	APH (changed lic. from 85 bed GACH 4/4/16)
Northridge Hospital Medical Center–See **Dignity Health Northridge** Hospital Medical Center						
Olive View Community Mental Health Urgent Care Center 14659 Olive View Drive Sylmar, CA 91342 [Open 8/2011; **d. 9/18/15; opened UCC-CSU 9/21/ 2015**] Ownership: County DMH District #5	1	2	James Coomes, LCSW MH Clinical Program Head (818) 485-0836; 485-0835 (818) 833-5690 FAX La Tina Jackson, MH Clinical District Chief, SA II Admin. (818) 610-6708 OV CMH UCC (818) 485-0888	C & MHSA	8 Convertible chairs	Not Licensed
Pacifica Hospital of the Valley 9449 San Fernando Road Sun Valley, CA 91352 (818) 767-3310 Ownership: Doctors Community Health Care Corp. District #3	1	2	Ayman Mousa, CEO (818) 252-2490; 2495 Melissa Mitchell, CNO (8'15) (818) 252-2492 direct; -2383 (818) 252-2478 FAX Dana LaVerne-Prog. Mgr. 1'17 Omorogiuwa (Maureen) Adenye-BHS Dir. 12'16 (818) 252-2284;-2299; -2380 (818) 252-2141 FAX (800) 522-1154 (Intake) (818) 252-2271 BHU (818) 252-2288 FAX- Unit	FC	36 [+4 ER holding area beds lic. 12'12]	GACH
Pacific Hospital of Long Beach - See **College Medical Center**			**New Owner**: College Health Enterprises 10/8/2013			
Penn Mar Therapeutic Center 3938 N. Cogswell Road El Monte, CA 91732 Ownership: Mitch Kantor District #1	1	3	Dori Dimla, Administrator (626) 401-1557 x221 Kathy Snyder, DON x311 Jorge Saldana, Prog. Dir. (626) 401-1557 x331 (626) 401-0024 FAX (626) 401-1559 x261 Unit	CGF	45	SNF
Providence Little Company of Mary Medical Center San Pedro* 1300 W. 7th Street San Pedro, CA 90732 (310) 832-3311 Outpatient Center for Crisis Stabilization (CSU) 1386 W. 7th Street, #A [Pending] San Pedro, CA 90732 Ownership: Providence Health System – Southern California District #4	1 (5)	8	Mary Kingston, CEO Anne Lemaire- Admin. 1'16 (310) 514-5494; 514-5314 FAX Colleen Wilcoxen, CNO 1'17 (310) 241-4081; 514-5323 FAX Paula Austin-Ghandehari-BH Dir. (310) 241-4349 2'17 (310) 514-4314 FAX (310) 514-5359 Bridges Unit (310) 241-4335 OP Ctr- CSU	FC	25 [Pending 20 chair-bed OP CSU; d. survey 5/9/17]	GACH

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Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Resnick Neuropsychiatric Hospital at UCLA [R-NPH @ UCLA] 150 Medical Plaza Los Angeles, CA 90095 (310) 825-0511 [**new site** 6/29/08]	1,2,3,4 (5) (6-DBS)	5	Peter C. Whybrow, MD, CEO-R-NPH; Dir.-NPI (310) 206-1233 (**old site**) (310) 825-3942 FAX [**new site**]	FC	74 (49 Adlt., 25 Youth)	APH
Ronald Reagan UCLA Medical Center 757 Westwood Plaza Los Angeles., CA 90095 (310) 267-9302 [**new name/site** 6/29/08]: [456 beds] Amir Dan Rubin, CEO		5	Thomas Strouse, MD, Med. Dir. (Suite 4230B) (310) 267-9159; FAX -3683 Pat Matos, DON (3/2013) (310) 267-9152 (310) 267-3618 FAX Colleen Davidson, QM Dir. (310) 267-9076; 267-9092 (Suite 4230C; MC746330)	FC	**[new site** 6/29/08] **R-NPH** 74 beds- 3 pods:	GACH
Resnick Neuropsychiatric Hosp. at UCLA [**old site**]: 760 Westwood Plaza Los Angeles, CA 90024 UCLA Medical Center [**old name/site**]: 10833 Le Conte Avenue Los Angeles, CA 90095 (310) 825-9111			(310) 267-2021 FAX [**new site**] (310) 267-7375 Child-4W (310) 267-7377 Adol.-4W (310) 267-7373 Adol. ED-4W (310) 267-7411 Adlt.-4E (310) 267-7418 Adlt. ICU-4E (310) 267-7365 Geri.-4N (310) 267-7496 Adlt. ED-4N		4 West Ch/Adol.- 25 beds; 4 East Adlt/Dual- 24 beds; 4 North Gero/ED- 25 beds (Gero/Med-17, ED-8)	
Ownership: UCLA Health System District #3			(310) 267-8400 ER			
San Gabriel Valley Medical Center* 438 West Las Tunas Drive San Gabriel, CA 91776 (626) 289-5454	4	3	Karen Price-Gharzeddine, CEO (626) 289-5454 7'15 (626) 570-6555 FAX Francis Largoza, CNO 11'16 (626) 570-6610 Rita Stuckey-Int. BMC Prog.Dir (626) 300-7326 11'16 Mariano Gallegos-Clin. Coord		42 (gero) (lic. 6'11; +4 beds out of suspension 6'12; d. 7'11)	GACH
Ownership: AHMC Healthcare Inc. District #5			(626) 300-7300 Gero Unit (626) 300-7373 FAX			
Sherman Oaks Hospital* 4929 Van Nuys Boulevard Sherman Oaks, CA 91403 (818) 981-7111	4	2	Bockhi Park, CEO 8'12 Roland Santos, CNO x4540 (818) 907-4500; 205-1996 (818) 907-2829 FAX Em Garcia, Admin. 5'13 (818) 205-1997 Wayne Hoo- Dir. - Psych. Svcs. (818) 907-2847 5'17 (818) 907-4534 FAX Shirley Sunn- CrisisTm 205-1976 Intake- 1-866-964-9221	P	19 (gero) [d. 9/2010]	GACH
Ownership: Prime Healthcare (Prem Reddy) District #3			(818) 205-1900 Gero Unit-2W			

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
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Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Silver Lake Medical Center* 1711 West Temple St. Los Angeles, CA 90026 (213) 989-6100 Silver Lake Medical Center- Ingleside 7500 E. Hellman Ave. Rosemead, CA 91770 (626) 288-1160 Ownership: Success Healthcare 1, LLC District #1	1 1	1 3	Michael Phillips, CEO 4'17 (213) 989-6117-asst. Kim S. (213) 484-3292 FAX; -3552 Nikki Cunningham, CNO (213) 989-6113 '16 Maya Papandrea (Mae Famor)-VP-Beh. Hlth. x814 5'13 (626) 571-4880 FAX **SLMC- L.A.** BHU (5th Floor) Pinky Biag, DON (213) 484-3253, -3565, -3588 (213) 484-3229 FAX **SLMC- Inglsd.** (626) 288-1160 (626) 571-4880 FAX Pinky Biag, DON x853 9'13 SLMC-Ingl. BH Units: N-x619; S- x606; E -x406; W -x608	FC	147 lic. (143 in use) 29 beds (LA site- 4/2009) 114 beds (Inglsd. N/S/W/E; Pav. C- 18 beds **7'15**; East Pav.- 26 beds 7'11)	GACH [Pending Sale]
[See **Non-Designated Acute Inpatient Facilities]** Southern California Hospital at Culver City* 3828 Delmas Terrace Culver City, CA 90231 (310) 836-7001 [**new name** 11'13] Southern California Hospital at Hollywood 6425 De Longpre Avenue Los Angeles, CA 90028 (323) 462-2271 [**new name** 11'13] Ownership: Southern California Healthcare System, Inc.; Prospect Medical Holdings, Inc. District #2	1,4	5	Sean Fowler, CEO 10'16 (310) 836-7000, x1010 Gail Foster, Int. CNO 2'17 (310) 836-7000 x1006 Lawrence Story-VP, BH-Alta ; Admin., Psych. Svcs. 3'17 (310) 422-7453 cell (310) 202-4129 FAX Nancy Bukowski - BH DON (310) 486-2673 cell 2'17 Nsg Mgrs (310) 836-7000 x6613 (310) 202-4129 FAX (310) 202-4793 BHU Unit C-x6620; P6-x6600	FC	70 **Vol.** (18 Gero., 52 Adult) [**4/4/2017**- LPS desig. **termed**; now 70 **Vol.** beds]	GACH
Star View Adolescent Center 4025 W. 226th Street Torrance, CA 90505 (Peter Zucker, Exec. Director) Ownership: Mary Jane Gross District #4	2	8	Natalie Spiteri, Admin. (9/10) (310) 373-4556 x123 (310) 373-2826 FAX Gerald Vanderburg, DON Colette Esparza, QA Dir. x111 Andrew Levander, Clin. Dir. x120 Nicole Klasey, Dir. Trt. Svcs. (310) 373-4556 Kelly McMahon-Dir. Res. Svcs (310) 373-4556 x280 PHF	CGF	16	PHF
St. Francis Medical Center* 3630 Imperial Highway Lynwood, CA 90262 (310) 900-8900 Ownership: Verity Health System 12'15 [Mgt.- BlueMountain- Integrity Healthcare] District #2	1	6	Gerald Kozai, Pres./CEO (310) 900-7301 Derek Drake, CNO 1'17 (310) 900-8573 Bob Merritt-VP-Amb. & Special Svcs. (310) 900-8213; 900-7960 (310) 900-8286 FAX Bob Merritt-Int. BH Dir. DON-BHU- (310) 900-8254 Eric Osterlind, Clin. Supv. -8222 Jim McDaniel- Srvc. Line Dir. (310) 900-8211; 603-6587 FAX (310) 900-8210 BHU	FC	40 [pending 8 bed CSU]	GACH
USC University Hospital [see **Keck Hospital of USC** - name change 11/1/11]			Keck Hosp. of USC: **BHU closed** 11/1/2013			

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
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Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
USC Verdugo Hills Hospital* 1812 Verdugo Blvd. Glendale, CA 91208 (818) 790-7100 [**merger 7/16/13: formerly** Verdugo Hills Hosp.] Ownership: USC Verdugo Hills Hospital, LLC; Mgt: Horizon Health (Universal Health Services) District #5	4	2	Keith Hobbs, CEO Theresa Murphy, CNO (818) 952-2210; Elen Borja Luke Jackson, Prog. Dir. 8'14 (818) 952-3599 (818) 952-3549 FAX Ani Sananyan, Unit Mgr. (818) 952-3555 (818) 952-2270 Gero. Unit	P	24 (gero)	GACH
ValleyCare Olive View-UCLA Medical Center 14445 Olive View Drive Sylmar, CA 91342 (818) 364-1555 Ownership: County District #5	1	2	Judy Maass, CEO 4'17 (818) 364-3001 Bonnie Bilitch, CNO 6/16/17 Alex Kopelowicz, MD Chief of Psychiatry (818) 364-4823 (818) 364-3554 FAX Lois Ramirez, Asst. Hosp. Admin.-BH (818) 364-3001 (818) 364-3011 FAX 12'16 (818) 364-4448 Psy. Admin. Alicia Casapao- Nsg. Mgr. (818) 364-3758 (818) 364-4433 6A Unit	C	32 (Lic. for 80 beds) 6C (closed 10'07; PER overflow) (818) 364-3760	GACH (377 beds licensed, incl. 80 psych. beds) [PER-+20 new beds 7'15; prior 14 beds = overflow]
VA Greater Los Angeles Healthcare System [VA GLA] 11301 Wilshire Blvd. (Mail Code 10H5) Los Angeles, CA 90073 (310) 478-3711 Ownership: Federal District # N/A	1,4 (5-sent to RR UCLA MC) (6-DBS)	5	Ann Brown, Director (310) 268-3132; 268-4087sec Chief of Staff-Scotte Hartronfth (310) 268-3319 x83319 (310) 268-4377 FAX James Doelling, CNE Assoc Chief Nsg Svc, (310) 478-3711, x83229 Eileen Garrity- Nsg Svc–MH Barry Guze, MD-Chief.-Psych Chief, Mental Hlth. Care Line (310) 268-4497 Nurse Managers: Robert Kotecki Mgr 2WAB (310) 478-3711 x49833 10/17/16 (310) 268-4349 FAX Nicole Schmid-Nsg Mgr 2WCD Jennifer Smith-Mgr 2NBC Michelle Pinkney-Mgr 2SAB James Myles, Pt. Rels. Asst (310) 478-3711 x43445 Units: (310) 478-3711+ext x40661 & x40665 2North x48517 2WCD 268-4582 (direct for outside) (310) 268-4590 2WAB & (310) 478-3711 x48515 (310) 268-3497 2SAB (310) 268-3055 (**closed**) **2SCD**	Fed	70 (65 in use 5'13; (70 lic.) 5 Units: (4 open, 1 closed 2WAB-12 beds; 2WCD-23 beds Gen. Acute; 2SAB-15 of 20 Psych+CD; 2NBC-Geropsy. 20 beds; **2SCD-Gen/Dual 20 beds-(closed 8/08)** [2SAB renovation '13-'16]	GACH [Federal-no license required]

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
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Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
VA Long Beach Healthcare System Mental Health Healthcare Group (06) 5901 East 7th Street Long Beach, CA 90822 (562) 826-8000 Ownership: Federal District # N/A	1,4	8	Norman Ge, MD, Acting Director 12'16 (562) 826-8000 x5403, 5400 Jessie D'Agostino, Chief Mental Health Pt. Services (562) 826-8000 x2316 Joan Bates (562) 826-8000 x5601 (562) 826-5969 FAX Larry Albers, MD, Chief MH Care Group Katherine Kadrlik-Petrarca 1'17 Clin. Nurse Leader, L1 x3521 (562) 826-4520 M1 (562) 826-5879 L1 (562) 826-5438 ER	Fed	30 (15 Adlt., 15 Gero.)	GACH [Federal-no license required]
Verdugo Hills Hospital [see **USC Verdugo Hills Hospital** – merger 7/16/13]						
White Memorial Medical Center 1720 Cesar Chavez Ave. Los Angeles, CA 90033 (323) 268-5000 [New name pending 7'17- Adventist Health White Memorial] Ownership: Adventist Health West District #1	1	4	John Raffoul, Pres./CEO 3'15 Patricia Stone, SrVP/CNO (323) 268-5000, x1188 11'14 Stephanie Cota, Director of Behavioral Medicine & ED (323) 307-8967 Sybil Cross, Educ./Nsg. Mgr. (323) 265-5095 (323) 265-5035 BH Admin. (323) 881-8610 FAX Behavioral Health (323) 265-5037 Unit A (323) 265-5020 Unit B	FC	33	GACH

TOTAL # LPS Designated Facilities: **45** [does **not** include DSH-Metropolitan LA (**formerly** Metropolitan State Hospital)]

Legend:

Funding Source: CGF-County General Fund; P-Private; C-County; FC-Fee-for-Service / Medi–Cal Contract; Fed-Federal; MHSA-Mental Health Service Act Funds

Licensure Type: APH-Acute Psychiatric Hosp; GACH-General Acute Care Hosp; SNF-Skilled Nursing Facility; PHF-Psychiatric Health Facility; CTC-Correctional Treatment Facility

***Facilities that provide mobile field assessment (PET)**

Program: 1-Adult, 2-Adolescent, 3-Children, 4-Geriatric, (5-ECT); (6-DBS)

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Non-Designated Acute Inpatient Facilities

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Cedars–Sinai Medical Center- Thalians 8730 Alden Drive, C301 Los Angeles, CA 90048 Cedars-Sinai Medical Center 8700 Beverly Blvd. Los Angeles, CA 90048 Ownership: Cedars-Sinai Health System District #3	1 (5)	4	Thomas M. Priselac-CEO/Pres. Mary Cirricione, DON; -4715 (310) 423-4897 Anand Pandya, MD Med. Dir. (310) 423-3615 (310) 423-8397 FAX (310) 423-4748 3W-24 beds; 3E-27 beds -3621 Closed 12/2010	FC	[51] **Closed 3/9/12** [No Invol. adms. after 11/30/10; no vol. & ECT 3'12]	GACH
L.A. Community Hospital at Bellflower 9542 E. Artesia Blvd. Bellflower, CA 90706 (562) 273-1800 [**form.** Bellflower Med. Ctr.; BHU **closed 4/13,** Lic. in suspense **5'13; sold 5/2014** to Alta] Ownership: L. A. Community Hosp. (Alta Hospitals System, Inc.) District #4	1	7	Harvey Ross, CEO (323) 482-3375 Lucy Avila, CNO (562) 228-9195; 273-1818 FAX Tom Purkiss, BHS Prog. Dir. (562) 228-9197 (562) 273-1830 BHU (562) 273-1831 FAX	FC	32 [open (Vol) 7/23/2015; plan to add 60 beds 2018]	GACH
Motion Picture & Television Fund Hospital- (See **LPS Designated Facilities** list) d. 9/12/16						
Ocean View Psychiatric Health Facility 2600 Redondo Avenue, Suite 500 Long Beach, CA 90806 Ownership: Mgt-Collaborative NeuroScience District #4	1	8	Dalia Botros, Admin. (714) 348-2015 Jill Schmidt, DON (562) 477-7503; 348-2439 cell (844) 562-1212 Intake (562) 981-0304 FAX (562) 304-1750 PHF	P	20	PHF
Southern California Hospital at Culver City* 3828 Delmas Terrace Culver City, CA 90231 (310) 836-7001 [**new name** 11'13] (**formerly** Hollywood Com. Hospital at Brotman Medical Center; **1/1/13-** under **one license** with HCH of Van Nuys & HCH at Hollywood) Southern California Hospital at Hollywood 6425 De Longpre Avenue Los Angeles, CA 90028 (323) 462-2271 [**new name** 11'13] Ownership: Southern California Healthcare System, Inc.; Prospect Medical Holdings, Inc. District #2	1,4	5	Sean Fowler, CEO 10'16 (310) 836-7000, x1010 Gail Foster, Int. CNO 2'17 (310) 836-7000 x1006 Lawrence Story-VP, BH-Alta Admin., Psych. Svcs. 3'17 (310) 422-7453 cell (310) 202-4129 FAX Nancy Bukowski - BH DON (310) 486-2673 cell 2'17 Nsg. Mgrs: (310) 836-7000 x6613; Gero; ITU/P4 (310) 202-4129 FAX (310) 202-4793 BHU; Unit C-x6620; P6-x6600	FC	70 (18 Gero., 52 Adult) [LPS d. termed **4/4/2017**; now **Vol.**] (Plan to add 35 Vol. beds on P4- Adults mid-2017)	GACH
Southern California Hospital at Van Nuys 14433 Emelita Street Van Nuys, CA 91401 [**formerly** HCH of Van Nuys- **new name** 11'13] (**1'13- under one license** with **HCH at Brotman MC& HCH at Hollywood)** Southern California Hospital at Hollywood 6425 De Longpre Avenue Los Angeles, CA 90028 (323) 462-2271 [**new name** 11'13] Ownership: Southern Cal. Healthcare System, Inc. District #3	1	2	Nina Rosenfeld, CEO (818) 787-1511 x200, x203 (818) 530-0519 FAX (818) 787-6739 FAX Veronica Cortez-ACNO x209 10'16 (818) 787-1511 x108 Unit 1 (818) 787-1511 x240 Unit 2 Advocate: Alex Velasquez	P	59 lic. (57 beds in use- 36 locked vol., 21 open vol.)	GACH
Tarzana Treatment Centers 18646 Oxnard Street Tarzana, CA 91356 (888) 777-8565 Ownership: Tarzana Treatment Centers Inc. District #5	1	2	Albert Senella, Pres. & CEO (818) 345-3778 FAX Ken Bachrach, PhD-Clin. Dir. (818) 654-3806 (818) 758-9182 FAX East Unit Advocate :	P	60 (East-38; West-22 beds)	APH

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Non-Designated Sub-Acute Residential Facility						
Vista Del Mar Child & Family Services 3200 Motor Ave. Los Angeles, CA 90034 District # 2	2	5	Dina Bernat-Kunin, Prog. Dir. (310) 836-1223 x215 (310) 836-2162 FAX Advocate: Joan Miller		68 Resid. 22fe/22ml 24 CTF	**CTF** [Community Treatment Facility]

IMDS

IMD Office # (213) 738-4775

Mary Marx, L.C.S.W., Long Term Care Program Director- # (213) 272-8468

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Alpine Special Treatment Center (sub-acute) 2120 Alpine Boulevard Alpine, CA 91901 Ownership: District #	1		Kristin Allred, Admin. (619) 445-2644 (619) 445-0444 FAX IMD: Peter McCarthy, LPT Cell: (213) 305-3661 Adv.:	CGF		
Community Care Center 2335 S. Mountain Avenue Duarte, CA 91010 Ownership: County Care Center, Inc. District #5	1	3	Barbara O'Connor, Admin. (626) 357-3207 (626) 303-1116 FAX Patricia Lopez, RN Cell: (213) 305-3523 Sossy Semerdjian, PG Sup. (213) 974-0645 Peer Adv. Dan Scheibly Pager: (213) 208-0285 IMD: Alicia Ibarra Cell: (213) 305-3628 Adv: Vanessa Estrada	CGF	167	SNF
Harbor View Behavioral Health Center 490 West 14th Street Long Beach, CA 90813 (562) 591-8701 (**formerly** Harbor View Adolescent Center; **Adol. closed** 7/18/14; Lic. in suspense 7/18/14) Ownership: Genesis Healthcare Group District #4	1	8	Wendy McLearie-Admin. (562) 591-8701 x240 10'14 (562) 591-0235 FAX Saham Plong, DON x242 (562) 591-9851 FAX Maria Pedraza, HIM x262 IMD: Eric Howell, LMFT Cell (213) 471-0427 Adv.: (562) 591-8701, x223 Nsg. Sta.	CGF	39 [**opened** as **Adult IMD 1/13/2015**]	SNF (Lic. out of suspense 1/13/15)
Landmark Medical Center 2030 N. Garey Avenue Pomona, CA 91767 Ownership: Marshall Horseman District #1	1	3	Rosemary Kilby, Admin. (909) 593-2585 Prg. Dir: Octavio Arceo (909) 593-2585 (909) 593-4120 FAX Joy Wykoff, PG Supervisor (213) 974-0596 IMD: Cheryl Lopez Cell: (213) 804-5449 Peer Adv: Elisabeth Schoeler Pager: (323) 502-5138 Adv:	CGF		SNF
Laurel Park Behavioral Health Center 1425 W. Laurel Avenue Pomona, CA 91768 (takes Hearing Impaired Clients) Ownership: Genesis District #1	1	3	Sylvia Rodriguez, Admin. (909) 622-1069 (909) 622-1319 FAX; -4319 Prog. Dir: Juan Hurd (909) 622-1069 Sossy Semerdjian, PG Sup. (213) 974-0645 IMD: Cheryl Lopez Cell: (213) 804-5449 Peer Adv. Penny Lyles Pager: (213) 287-5634 Adv:	CGF	43	SNF (STP)

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Laurel Park Behavioral Health Center 1425 W. Laurel Avenue Pomona, CA 91768 (takes Hearing Impaired Clients) Ownership: Genesis District #1	1	3	Sylvia Rodriguez, Admin. (909) 622-1069 (909) 622-1319 FAX; -4319 Prog. Dir: Juan Hurd (909) 622-1069 Sossy Semerdjian, PG Sup. (213) 974-0645 IMD: Cheryl Lopez Cell: (213) 804-5449 Peer Adv. Penny Lyles Pager: (213) 287-5634 Adv:	CGF	43	SNF (STP)
La Casa M. H. Rehab. Center (sub-acute) 6060 Paramount Blvd. Long Beach, CA 90805 Ownership: Telecare Corporation District #4	1	8	Larry Lawler, Admin. (562) 634-9534 (562) 634-8354 FAX; -8404 Mary Ocole, DON x128 Sossy Semerdjian, PG Sup. (213) 974-0645 IMD: Eric Howell, LMFT Cell (213) 471-0427 Peer Adv: Penny Lyles Pager: (213) 287-5634 Adv: Maureen Edwards Love	CGF	190 Sub-Acute	MHRC
La Paz (sub-acute) 8835 Vans Street Paramount, CA 90723 Ownership: Telecare District #4	1	6	Richard Widerynski, Admin. (562) 633-5111 (562) 408-1120 FAX Sossy Semerdjian, PG Sup. (213) 974-0645 IMD: Jenna Jreisat Cell: (213) 924-9363 Peer Adv: Rhonda Layton Pager: (213) 919-0352 Adv: Maureen Edwards Love	CGF	Sub-Acute 16 psych. Beds	SNF
Meadowbrook Manor 3951 East Boulevard Los Angeles, CA 90066 Ownership: Genesis District #2	1	5	Michael Meyer, Admin. (310) 391-8266 (310) 390-9878 FAX Rudy Duarte, PG Sup. (213) 974-0645 (213) 974-0534 IMD: Rebekah Woolery LCSW Cell: (213) 271-6805 Peer Adv: William Hamilton Pager: (323) 341-3221 Adv:	CGF	10 indigent beds	SNF
Olive Vista Behavioral Health Center 2350 Culver Court Pomona, CA 91766 Ownership: Genesis District #1	1	3	Robert Barton, Admin. (909) 628-6024 (909) 628-1839 FAX Prg. Dir: Mariela Pizzatti Sossy Semerdjian, PG Sup. (213) 974-0645 IMD: Cheryl Lopez Cell (213) 804-5449 IMD: Peter McCarthy, LPT Cell: (213) 305-3661 Peer Adv: Dan Scheibly Pager: (213) 208-0285 Adv.:	CGF	20 indigent beds; 120 beds	SNF

LPS DESIGNATED/NON-DESIGNATED/IMD FACILITIES
LOS ANGELES COUNTY

Revised 7/10/2017

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Shandin Hills Behavioral Health Center 4164 N. 4th Avenue San Bernardino, CA 92407	1		Sandra Faay, Admin. (909) 886-6786 (909) 886-2953 FAX IMD: Peter McCarthy, LPT Cell: (213) 305-3661		47	SNF
Sierra Vista Behavioral Health Center 3455 E. Highland Ave. Highland, CA 92346 (takes Deaf Clients)	1		Jeanine Allspaw, Admin. (909) 862-6554; -6454 (909) 862-6474 FAX; 864-1337 IMD: Peter McCarthy, LPT Cell (213) 305-3661		116	SNF
Sylmar Health and Rehabilitation Center 12220 Foothill Boulevard Sylmar, CA 91342	1	2	Brit Nell, Admin. (818) 834-5082 ext. 101 (818) 834-5981 FAX		4	SNF
View Heights Convalescent Hospital 12619 S. Avalon Blvd. Los Angeles, CA 90061 Ownership: Amada Corporation District #2	1	6	John Jones, Admin. (323) 757-1881 (323) 757-0601 FAX Leticia Rivera, Prog. Dir. Bettye Thompson, PG Sup. (213) 974-0504 IMD: Rebekah Woolery LCSW Cell: (213) 271-6805 Peer Adv.: Rhonda Layton Cell: (213) 434-0587 Adv.: Johanna Hopkins	CGF		SNF

URGENT CARE CENTERS (UCCs) – NON-DESIGNATED

Facility Name/Address	Program	Service Area	Facility Telephone Number/Contact Person	Funding Source	Number of Psych Beds	Licensure Type
Mental Health Urgent Care at MLK by Exodus (See **LPS Designated Facilities** list)			d. 9/4/14			
Mental Health Urgent Care Center at Long Beach (La Casa) 6060 Paramount Blvd. Long Beach, CA 90805 (562) 790-1860 Ownership: Telecare Corp. District #4	1	8	Bryceton Danico, Admin. David Heffron, Reg. Dir. Ops (562) 634-9534, x143 (562) 634-8354 FAX Anne Stamme, RN Scott Alpert, Social Wrkr. (562) 790-1860 UCC	C	6 Convertible chairs	Not Licensed
Olive View Community Mental Health Urgent Care Center (See **LPS Designated Facilities** list)			d. 9/18/2015; open 9/21/15			

Legend:

Funding Source: CGF-County General Fund; P-Private; C-County; FC-Fee-for-Service/Medi–Cal Contract; Fed-Federal; MHSA-Mental Health Services Act.
Licensure Type: APH-Acute Psychiatric Hosp; GACH-General Acute Care Hosp; SNF-Skilled Nursing Facility; PHF-Psychiatric Health Facility; MHRC-Mental Health Rehabilitation Center; CTC-Correctional Treatment Center; CTF-Community Treatment Facility.
Program: 1-Adult, 2-Adolescent, 3-Children, 4-Geriatrric, (5-ECT), (6-DBS).
IMD=IMD liaison (DMH) PG Sup= public guardian supervisor
Countywide Resource Management (CRM) Office # (213) 738-4775; Mary Marx, LCSW, CRM District Chief
Access Center # (800) 801-7886 -1 [Gatekeeping (Short-Doyle Beds; Psych. Diversion Beds)]; **AB 109 (213) 738-2877**

DEPARTMENT OF MENTAL HEALTH – LOS ANGELES COUNTY
INVENTORY OF COUNTY 5150 DESIGNATED FACILITIES

Date Revised – 4/5/2017

COUNTY MENTAL HEALTH INFORMATION

LOS ANGELES	Jonathan E. Sherin, MD, PhD, Director	jsherin@dmh.lacounty.goc
(County)	(County Mental Health Director)	(Email Address)
550 South Vermont Avenue, 12th Floor	Los Angeles	California 90020
(Number, Street, or Post Office Box)	(City)	(State) (Zip Code)
(213) 738-4601	(213) 386-1297	
Telephone (Area Code/Number)	FAX (Area Code/Number)	

COUNTY 5150 DESIGNATED 24-HOUR LICENSED INPATIENT HEALTH FACILITIES
(Does not include facilities that ARE NOT physically located in the county.)

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER	NUMBER OF PSYCH. BEDS	FACILITY TYPE OR LICENSE
Antelope Valley Hospital	1600 West Avenue J Lancaster, CA 93534	(661) 949-5000; (661) 949-5250 MHU	14	GACH
Aurora Charter Oak Hospital	1611 East Covina Boulevard Covina, CA 91724	(626) 966-1632	134 (30 Adol.)	APH
Aurora Las Encinas Hospital	2900 East Del Mar Boulevard Pasadena, CA 91107	(626) 795-9901	118	APH
BHC Alhambra Hospital	4619 North Rosemead Boulevard Rosemead, CA 91770	(626) 286-1191	97 (32 Ch./Adol.)	APH
Brotman Medical Center (See **So. Cal. Hosp.@C.C.**)				
Citrus Valley Medical Center-Inter-Community	210 West San Bernardino Road Covina, CA 91723	(626) 331-7331 (626) 938-7650 MHU	30	GACH
College Hospital	10802 College Place Cerritos, CA 90703	(562) 924-9581	187 (42 Adol.)	APH
College Medical Center (form. **Pacific Hos-Long B**) (Hawthorne campus-pur. 7'14, lic. 11/24/15)	2276 Pacific Avenue Long Beach, CA 90806 1725 Pacific Avenue Long Beach, CA 90806 13300 South Hawthorne Boulevard Hawthorne, CA 90250	(562) 997-2000 Main (562) 256-8400 South (424) 365-3000	137 (Main-37, So.-36) (H-64, d. 11/30/15, open 1/6/16)	GACH
Community Hospital of Long Beach	1720 Termino Avenue Long Beach, CA 90804	(562) 494-1000 (562) 494-0581 MHU	28	GACH
Correctional Treatment Center-Mental Health	Twin Towers-Medical Services Building, 4 East 450 Bauchet Street Los Angeles, CA 90012	(213) 893-5392 MHU	43	MHU of Correctional TC
Del Amo Hospital	23700 Camino Del Sol Torrance, CA 90505	(310) 530-1151	166 (14 Ch./32 Adol.)	APH
Dignity Health **Northridge** Hospital Medical Center	18300 Roscoe Boulevard Northridge, CA 91328	(818) 885-8500	40 (9 Adol.)	GACH
East Valley Hosp. Med. Ctr. (See **Glendora Com.**)				
Encino Hospital Medical Center	16237 Ventura Boulevard Encino, CA 91436	(818) 995-5000 (818) 995-5174 MHU	13 Gero	GACH
Exodus Recovery Psychiatric Health Facility	9808 Venice Boulevard, 3rd Floor Culver City, CA 90232	(310) 237-0454	16	PHF
Exodus Recovery UCCs (See below- **Other Types**)	**See page 4: Other Types of County 5150 Designated Facilities**			**Unlicensed** UCC
Gateways Hospital & Mental Health Center	1891 Effie Street Los Angeles, CA 90026	(323) 644-2000	55 (27 Adol.)	APH
Glendale Adventist Medical Center	1509 Wilson Terrace Glendale, CA 91206	(818) 409-8000 (818) 409-8027 Psyc. Inst.	60	GACH

DEPARTMENT OF MENTAL HEALTH – LOS ANGELES COUNTY
INVENTORY OF COUNTY 5150 DESIGNATED FACILITIES

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER	NUMBER OF PSYCH. BEDS	FACILITY TYPE OR LICENSE
Glendale Memorial Hospital & Health Center	1420 South Central Avenue Glendale, CA 91204	(818) 502-1900 (818) 502-2362 BHU	30	GACH
Glendora Community Hospital (form. **East Val.**)	150 West Route 66 Glendora, CA 91740-6307	(626) 852-5000 (626) 852-5063 MHU	21 Gero.	GACH
Harbor-UCLA Medical Center	1000 West Carson Street Torrance, CA 90509	(310) 222-2345	38	GACH
Harbor View Adolescent Center (**closed** 7/2014)				
Henry Mayo Newhall Hospital	23845 West McBean Parkway Valencia, CA 91355	(661) 253-8000 (661) 253-8954 MHU	23	GACH
Hollywood Com. Hos. at Brotman MC (See **So.Cal**)				
Huntington Hospital-Della Martin Center	100 West California Boulevard Pasadena, CA 91105-7013	(626) 397-5000 (626) 397-2324 DMC	50 (38 in us; 14 Gero.)	GACH
Kaiser Permanente Mental Health Center; Kaiser Permanente Los Angeles Medical Center	763 West College Street Los Angeles, CA 90012 4867 West Sunset Boulevard Los Angeles, CA 90027	(213) 580-7200 (323) 783-4011 ((323) 783-8100 Admin.	68	GACH
Keck Hospital of USC (BHU **closed** 11/2013)				
Kedren Acute Psychiatric Hospital and CMHC	4211 South Avalon Boulevard Los Angeles, CA 90011	(323) 233-0425	72 (17 Child)	APH
LAC+USC HealthCare Network; LAC+USC Medical Center & A.F. Hawkins campus	Inpatient Clinical Tower 1200 North State Street Los Angeles, CA 90033 2051 Marengo Street Los Angeles, CA 90033 1720 East 120th Street Los Angeles, CA 90059	(323) 409-2800 Admin. (323) 409-1000 MC (424) 338-2564 AFH	 76 (11 Adol.)	GACH
La Casa Psychiatric Health Facility	6060 Paramount Boulevard Long Beach, CA 90805	(562) 634-9534 (562) 630-8672 PHF	16	PHF
Los Angeles Jewish Home For The Aging; Joyce Eisenberg-Keefer Medical Center	7150 Tampa Avenue Reseda, CA 91335	(818) 774-3200 JHA (818) 758-5041 MHU (818) 774-3000 JEKMC	10 Gero.	APH
Los Angeles Metropolitan Medical Center (Western & Hawth.) (**closed** 4'13; H-**sold** to **College** 7'14)				
Mental Health Urgent Care at MLK by Exodus (See below- **Other Types**)	**See page 4: Other Types of County 5150 Designated Facilities**			**Unlicensed** UCC
Mission Community Hospital	14850 Roscoe Boulevard Panorama City, CA 91402	(818) 787-2222 (818) 904-3104 MHU	60	GACH
Motion Picture & Television Fund Hospital	23388 Mulholland Drive Woodland Hills, CA 91362	(818) 876-1888	12 Gero.	APH
Northridge Hospital Medical Center	**See page 1: Dignity Health** Northridge Hospital Medical Center			
Olive View Community MH Urgent Care Center (See below- **Other Types**)	**See page 4: Other Types of County 5150 Designated Facilities**			**Unlicensed** UCC
Pacifica Hospital of the Valley	9449 San Fernando Road Sun Valley, CA 91352	(818) 767-3310 (818) 252-2271 BHU	36	GACH
Pacific Hospital of Long Beach (See **College Medical Center**)				

DEPARTMENT OF MENTAL HEALTH – LOS ANGELES COUNTY
INVENTORY OF COUNTY 5150 DESIGNATED FACILITIES

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER	NUMBER OF PSYCH. BEDS	FACILITY TYPE OR LICENSE
Penn Mar Therapeutic Center	3938 North Cogswell Road El Monte, CA 91732	(626) 401-1557	45	SNF
Providence Little Company of Mary Medical Center San Pedro	1300 West 7th Street San Pedro, CA 90732	(310) 832-3311 (310) 514-5359 MHU	25	GACH
Resnick Neuropsychiatric Hospital at UCLA; Ronald Reagan UCLA Medical Center	150 Medical Plaza Los Angeles, CA 90095 757 Westwood Plaza Los Angeles, CA 90095	(310) 825-0511 R-NPH @UCLA (310) 825-4321 RR UCLA Medical Center	74 (25 Youth)	APH GACH
San Gabriel Valley Medical Center	438 West Las Tunas Drive San Gabriel, CA 91776	(626) 289-5454 (626) 300-7300 BHU	42 Gero.	GACH
Sherman Oaks Hospital	4929 Van Nuys Boulevard Sherman Oaks, CA 91403	(818) 981-7111 (818) 205-1900 BHU	19 Gero.	GACH
Silver Lake Medical Center (Main Campus; Ingleside Campus)	1711 West Temple Street Los Angeles, CA 90026 7500 East Hellman Avenue Rosemead, CA 91770	(213) 989-6100 (626) 288-1160	147 (Main-29) (Ingleside-118)	GACH
Southern California Hospital at Culver City (form. **Hollywood Com. Hosp. at Brotman**)	**See Page 4: Non-Designated Acute Inpatient Facilities [LPS Design. termed 4/4/2017]**			
Star View Adolescent Center	4025 West 226th Street Torrance, CA 90505	(310) 373-4556	16 (16 Adol.)	PHF
St. Francis Medical Center	3630 Imperial Highway Lynwood, CA 90262	(310) 900-8900 (310) 900-8210 MHU	40	GACH
USC University Hospital (See **Keck Hosp. of USC**; BHU **closed** 11/2013)				
USC Verdugo Hills Hospital (form. **Verdugo Hills Hospital**)	1812 Verdugo Boulevard Glendale, CA 91208	(818) 790-7100 (818) 952-2270 MHU	24 Gero.	GACH
ValleyCare Olive View-UCLA Medical Center	14445 Olive View Drive Sylmar, CA 91342	(818) 364-1555 (818) 364-4433 MHU	32 (in use-80 lic.)	GACH
(Veterans Administration) VA Greater Los Angeles Health Care System (WLA)	**See page 4: Other Types of County 5150 Designated Facilities**			**Unlicensed** Federal
(Veterans Administration) VA Long Beach Healthcare System	**See page 4: Other Types of County 5150 Designated Facilities**			**Unlicensed** Federal
Verdugo Hills Hospital (See **USC Verdugo Hills Hospital**)				
White Memorial Medical Center	1720 Cesar Chavez Avenue Los Angeles, CA 90033	(323) 268-5000	33	GACH

DEPARTMENT OF MENTAL HEALTH – LOS ANGELES COUNTY
INVENTORY OF COUNTY 5150 DESIGNATED FACILITIES

OTHER TYPES OF COUNTY 5150 DESIGNATED FACILITIES
(Does not include facilities that ARE NOT physically located in the county.)

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER	NUMBER OF PSYCH. BEDS	FACILITY TYPE OR LICENSE
Exodus Recovery Eastside Urgent Care Center	1920 Marengo Street Los Angeles, CA 90033	(323) 276-6400	16 (convertible chair-beds-6 TAY)	Unlicensed Urgent Care Center (UCC)
Exodus Recovery Urgent Care Center Westside	11444 W. Washington Boulevard Culver City, CA 90066	(310) 253-9494	12 (convertible chair-beds)(d. 12/14/15)	Unlicensed UCC
Mental Health Urgent Care at MLK by Exodus	12021 Wilmington Avenue Los Angeles, CA 90059	(562) 295-4617	22 (convertible chair-beds; 6 Adol.)	Unlicensed UCC
Olive View Community Mental Health Urgent Care Center-CSU	14659 Olive View Drive Sylmar, CA 91342	(818) 485-0888	8 (convertible chair-beds)(d. 9/18/15)	Unlicensed UCC
(Veterans Administration) VA Greater Los Angeles	11301 Wilshire Boulevard Los Angeles, CA 90073	(310) 478-3711	70	Unlicensed Federal GACH
(Veterans Administration) VA Long Beach Health	5901 East 7th Street Long Beach, CA 90822	(562) 826-8000	30 (15 Gero.)	Unlicensed Federal GACH

Total # LPS Designated Facilities in Los Angeles County: **45** Date Revised - 4/5/2017

NON-DESIGNATED ACUTE INPATIENT FACILITIES

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER	NUMBER OF PSYCH. BEDS	FACILITY TYPE OR LICENSE
Los Angeles Community Hospital at Bellflower	9542 E. Artesia Boulevard Bellflower, CA 90706	(562) 273-1800	32 (60 pending)	GACH
Ocean View Psychiatric Health Facility	2600 Redondo Avenue, Suite 500 Long Beach, CA 90806	(562) 304-1750	20 (14 locked)	PHF
Southern California Hospital at Culver City (form. **Hollywood Com. Hosp. at Brotman MC**)	3828 Delmas Terrace Culver City, CA 90231 [LPS Design. termed **4/4/2017**]	(310) 836-7001	70 (18 Gero.)	GACH
Southern California Hospital at Van Nuys	14433 Emelita Street Van Nuys, CA 91401	(818) 787-1511	59	GACH
Tarzana Treatment Centers	18646 Oxnard Street Tarzana, CA 91356	(888) 777-8565	60 (East-38; West-22)	APH

NON-DESIGNATED URGENT CARE CENTERS

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER	NUMBER OF PSYCH. BEDS	FACILITY TYPE OR LICENSE
Mental Health Urgent Care Center at Long Beach	6060 Paramount Boulevard Long Beach, CA 90805	(562) 790-1860	**6** (convertible chair-beds)	Unlicensed UCC

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS
FSP GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
FIELD-BASED SERVICES	**VIII.**	**8/09/2009**	**1 of 1**
		REVISION DATE **7/1/2017**	DISTRIBUTION LEVEL

PURPOSE: To establish parameters for what constitutes a field-based service.

DEFINITION:

1. Field-based services are those services provided in a location that has a different address than the clinic site. The choice of service delivery site is based on the client's recovery goals and possible transportation limitations. Examples include churches, parks, libraries, physical health care settings and residences.

2. Services provided within the same building, even if the building houses different programs are not field-based. The exception to this would be where a client residence and treatment program reside at the same address.

GUIDELINE: Mental health services will be delivered at a site conducive and comfortable to the client, with the goal to engage and retain the client in services. It is the responsibility of the provider to identify the most appropriate Service Location Code to describe the location in which services were provided. The complete listing of Service Location Codes may be found in the Integrated Systems Codes Manual.

Agencies are expected to provide services to clients in field-based settings according to individual client needs and desires. While the *preferred* performance-based criteria is at least 65%, if this percentage falls consistently below 40%, DMH may contact the agency to determine whether the services are in fact being delivered in the settings most conducive to individual client needs and desires or if additional agency technical assistance or support is required.

This percentage is calculated based on the total minutes billed within a month, excluding service location codes 11 and 53.

ATTACHMENT DMH-CIOB Service Location Codes

SERVICE LOCATION CODES

Identifies the location of services at which services were rendered.

Codes	Description	
03	School	
04	Homeless Shelter	(Effective 12-3-2007)
09	**Prison/Correctional Facility** *(Not applicable to FFS 2 providers)*	**(Effective 2-23-2009)**
11	Office	
12	Home	
13	Assisted Living Facility	(Effective 12-3-2007)
14	Group Home	(Effective 12-3-2007)
16	**Temporary Lodging, e.g. hotel**	**(Effective 2-23-2009)**
20	Urgent Care	
21	Inpatient Hospital	
22	Outpatient Hospital	
23	Emergency Room – Hospital	
25	Birthing Center	
26	Military Treatment Facility	
31	Skilled Nursing Facility – Without STP	
32	Nursing Facility – With STP	
33	Custodial Care Facility	
34	Hospice	
50	Federally Qualified Health Center	
51	Inpatient Psychiatric Facility	
52	Psychiatric Facility Partial Hospitalization	
53	Community Mental Health Center	
54	Intermediate Care Facility/Mentally Retarded	
55	Residential Substance Abuse Treatment Facility	
56	Psychiatric Residential Treatment Center	
71	State or Local Public Health Clinic	
99	Other Unlisted Facility	

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA CLIENT SUPPORTIVE SERVICES GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
CLIENT SUPPORTIVE SERVICES	**IX.**	**11/24/09**	**1 of 11**
		REVISION DATE **8/16/13**	DISTRIBUTION LEVEL: **2**

PURPOSE: To provide clarification and guidance to the Department of Mental Health's directly operated programs and contract providers on the proper use, billing and expense claiming of Mental Health Services Act (MHSA) Client Supportive Services (CSS) Funds.

DEFINITIONS: **Client Supportive Services (CSS)**

Services provided by MHSA programs that are not billed through units of service that support a client in his/her recovery, including housing, employment, education, and integrated treatment of co-occurring mental illness and substance abuse disorders.

CSS Funds

CSS funds are allocated as an aggregate pool of funds that should only be used under special circumstances and as a last resort. They are client specific and are only intended to cover the cost of additional and/or alternative supports and services directly related to the client's service plan that lack funding or for which there is no traditional payment mechanism available.

The service provider is responsible for utilizing CSS funds in a manner that is clearly tied to the client's treatment and recovery goals.

Items must be used in the fiscal year in which they are purchased. When using CSS funds to purchase services, the services must be delivered to the recipient in the fiscal year in which they were purchased.

If an expense need is determined to be ongoing, the program must develop a plan for client self-sufficiency related to the ongoing expense.

For housing expenses that span <u>beyond 6 months</u>, contract providers must submit to the MHSA Age Group District Chief the *Supplemental Information Request Form* (Attachment) indicating how the ongoing expense directly relates to the client/family's

Client Care Coordination Plan and steps the provider has taken to secure alternative sources of funding (Section 8, employment, family financial support, etc.).
For other ongoing expenses such as medication, household utilities or ongoing gift cards for specific clients that span beyond 3 months, contract providers must submit to the MHSA Age Group District Chief the *Supplemental Information Request Form* (Attachment) indicating how the ongoing expense directly relates to the client/family's Client Care Coordination Plan and steps the provider has taken to secure alternative sources of funding for the expense.

Mode of Service

Mode of Service describes a classification of service types used for Client and Services Information System (CSI) and Cost Reporting. This allows any mental health services type recognized by DMH to be grouped with similar services. Modes of Service not allowable under CSS are:

- 05 (24 Hour Services)
- 10 (Less than 24 Hour Day Treatment Program Services)
- 15 (Outpatient Services)
- 45 (Outreach Services)
- 60 (Support Services)

Service Function Codes (SFC)

Numeric billing codes used to identify a service or service category within a Mode of Service used for billing purposes.

The following SFCs pertain to the use of CSS:

1. **SFC 70:** Expenses related to providing housing supports, including housing subsidies for permanent, transitional and temporary housing; master leases, security deposits and other fiscal housing supports. SFC 70 is only authorized for

FSP programs and MHSA Innovation programs. Examples of common SFC 70 expenses are listed in the CSS Expenditure Coding Guide, (Attachment).

SFC 70 **does not** include:

- the capital development expenses such purchasing, building and/or rehabilitating housing,
- the salaries and benefits of staff used to provide client housing supports,
- costs reported under Modes 05, 10, 15 or 45
- Units of Service

2. **SFC 71:** Expenses related to the operational costs of providing housing supports to clients including building repair and maintenance, utilities and other operating costs incurred in providing client housing supports. Examples of common SFC 71 expenses are listed in the CSS Expenditure Coding Guide (Attachment).

   SFC 71 **does not** include:

   - the capital costs used to purchase, build and/or rehabilitate housing,
   - the salaries and benefits of staff used to provide client housing supports,
   - costs reported under Modes 05, 10, or 15,
   - Units of Service

3. **SFC 72:** Flexible client support expenditures relating to personal, community integration and/or educational client/family/caregiver services and supports.

   Gift Cards

   DMH directly operated programs should follow the DMH Gift Card Policy and Procedure. Contract providers who choose to purchase gift cards should purchase a small batch of gift

cards to cover the cost of personal, community integration and/or educational/family services and supports. A small batch refers to a limited supply anticipated to cover categorical expenditures over a 2 month period of time. Gift cards should not be routinely given to individual clients and should only be used to supplement a client's resources. Gift card allocations per month per client should not exceed $150, unless prior written approval is received from the MHSA age group District Chief.

Items must be used in the fiscal year in which they are purchased. When using CSS funds to purchase services, the services must be delivered to the recipient in the fiscal year in which they were purchased.

Contract providers are responsible for ensuring the cards are properly secured and accounted for by maintaining a gift card tracking system that includes the following information, at a minimum:

- Gift card vendor name
- Gift card serial number
- Date gift card was issued
- Name of client gift card was issued to
- Signature of client upon receipt of gift card
- Gift card balance
- Copies of receipts for purchases made with gift card
- Name and signature of authorized personnel who issued the gift card.

This gift card tracking system shall include a tracking log/database and internal procedures and controls including, but not limited to, dispersal and safety/security of the gift cards and how the items or services purchased relate to the client's service plan. The log/database should also be used to keep track that gift card distribution does not exceed $150/month for each client. Internal procedures should also include procedures to make clients aware of the non-

allowable purchases when using gift cards.

This information shall be available for review by DMH designee(s) upon request either at the agency or via copies of records sent as requested by DMH designee(s).

In compliance with the County's fiscal policy and procedures, MHSA contractors and directly-operated programs are required to report all unused gift cards on or before June 30 of each fiscal year.

Directly Operated as well a contract providers should report any lost or stolen gift cards to the Department of Mental Health's MHSA Implementation Unit immediately.

Gift card inventories, as well as all CSS expenditures, are subject to random audits by DMH and/or the Office of the Auditor-Controller at any time.

Medical Expenses

SFC 72 funding may also be used for medical, dental and optical care, prescriptions, and laboratory tests when the client or family member does not have insurance to pay for such care.

Alternative Healing Methods

Many cultures have alternative healing methods such as cupping, acupuncture or curandero services. These might be legitimately reimbursed from Client Supportive Services Funds. It would be expected these services would be appropriately coordinated, including any potential interactions with psychotropic medications, with other medical or mental health services as part of the client's overall treatment plan.

Examples of common SFC 72 expenses are listed in the

CSS Expenditure Coding Guide, (Attachment).

SFC 72 **does not** include:

- the salaries and benefits of staff used to provide client supportive services
- costs reported under Modes 05, 10, 15 or 45
- Units of Service

4. **SFC 78:** Pursuant to an agreement between the provider and the MHSA age group District Chief, the FSP program may use up to 10%* of their CSS funds for the cost of salaries, benefits and general operating expenses incurred by providing non Medi-Cal client support (specifically for the salaries of staff who are providing housing and employment development as well as for peer staff). Examples of common SFC 78 expenses are listed in the CSS Expenditure Coding Guide, (Attachment).
   * Age group lead District Chiefs may use discretion to approve amounts of greater than 10% in special circumstances that clearly support positive client outcomes.

   SFC 78 **does not** include:

   - costs reported under modes 05, 10, 15 or 45.
   - Units of Service

Providers are urged to remember the intent of CSS funding and maintain an appropriate balance between using funds to serve the needs of clients and their families which cannot be met in other ways, and using them to pay staff costs.

EXCLUDED PURCHASES:

Alcohol, tobacco, construction or rehabilitation of housing, buildings or offices, purchasing land or buildings, illegal substances and activities, sexually explicit materials, costs for staff to accompany clients on outings (sporting events, concerts, amusement parks, etc.), incentives, covering Medi-Cal Share of Cost, prescription medication otherwise available through Indigent medication or

prescription assistance programs, Service Extenders (refer to the Older Adults FCCS Guidelines Manual for directions on submitting invoices for Service Extenders), units of service costs reported under Modes 05, 10, 15 or 45, vehicles for programs.

REASONABLE PURCHASE LIMITS: Every attempt should be made to purchase items as economically as possible, including using vendors that sell previously-used merchandise where feasible (examples include Goodwill, Salvation Army, on-line vendors). Refer to *CSS Expenditure Coding Guide* for purchase limits for more commonly purchased items and goods.

ELIGIBILITY: Clients of all ages, ethnicities, cultures and conditions who meet MHSA focal population criteria are eligible to receive CSS. Expenditures should be considered on a case-by-case basis at the agency level. The use of funds is not an entitlement.

Individuals enrolled in MHSA programs and/or receiving MHSA services with insufficient funds to provide the materials and resources necessary to achieve their treatment goals are eligible. Family members/caregivers may also be eligible for SFC 72 expenditures.

Clients currently receiving government assistance and/or other income are only eligible to utilize CSS after it has been clearly established that there are insufficient funds available for their housing, personal/community integration, vocational and other expenses.

The client's clinical record shall document efforts showing that other community resources have been pursued/exhausted.

REIMBURSEMENT: DMH directly operated MHSA programs are required to adhere to internal, existing CAL-card, housing, guidelines, policies and procedures when claiming reimbursement of CSS expenditures.

Any expenses about which an MHSA provider is unsure should be reviewed with the age group lead/designee ***before making the expenditure/purchase*** to the appropriate countywide age group

MHSA administration unit for review and approval.

The judgment of DMH as to the allowability of any expenditure shall be final.

Invoices shall be submitted to the DMH Provider Reimbursement Unit.

The following documents and procedures are required for contract providers to receive reimbursement for CSS expenditures:

CSS Expenditure Coding Guide-Revised

CSS funds are intended to be portable and client-specific and therefore, the CSS Expenditure Coding Guide only includes the most common allowable expenses for each of the various CSS Service Function Codes. Individual expenses are unique to each client and are not necessarily limited to those listed. Other expenses may qualify if they meet the criteria for which CSS funds are intended.

There are several expenses that DMH deems unallowable under any circumstances. Those expenses are listed at the bottom of the coding summary as well as in this policy.

Expenses requiring pre-approval from MHSA age lead (for FSP) or Innovation model lead are noted.

CSS Expense Reimbursement Claim Form

Contract providers are required to itemize monthly CSS expenditures into the CSS Expense Reimbursement Claim Form before submitting it to DMH for review and payment. The CSS Expense Reimbursement Claim Form is an Excel spreadsheet designed to allow contract providers to easily enter their expenses into a self-calculating template.

Any revenue received for an expense already reimbursed by the

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Department (e.g. reimbursement from clients/families/caregivers after receipt of SSI) should be indicated on the CSS Expense Reimbursement Claim Form and subtracted from the expenditures. Providers must record and keep written records of all revenue received from clients, including arrangements where clients reimburse the FSP program on a routine basis.

Supplemental Information Request Form

The Supplemental Information Request Form (Supplemental Info Form) is used under the following circumstances:

- DMH management and/or claim processing staff need to request additional information regarding a particular claim.
- For documenting the need for ongoing expenses at 3 and 6 month intervals per page 1 of this policy.
- Where applicable, as part of a random review of expenditures, file review or during a site visit or other mechanism as requested by the appropriate Age Group Lead.

Agencies may choose, but are not required, to use the Supplemental Information Request Form as part of their own internal documentation system for monitoring CSS expenditures.

The Supplemental Information Request Form allows for the provision of more detailed information regarding specific expenditures that easily allows approving managers or claim processing staff to see the reason for a particular expense, how it relates to the client's treatment and that CSS funds were used as a last resort after other resources were explored.

Contractors are required to archive all of their CSS expenditure receipts for a period of at least six (6) years. There may be occasions when a copy of an archived receipt is requested.

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CSS Expense Claim Processing Flow Chart

The CSS Expense Claim Processing Flow Chart provides a visual display of how a CSS Expense Claim is normally processed, as well as the ways in which the process can vary when claims are completed incorrectly, when DMH management requests additional information or as part of a random review of expenditures, file review or during a site visit or other mechanism as requested by the appropriate Age Group/Innovation Model Lead.

PROPERTY PURCHASED WITH CSS FUNDS:

Items purchased with CSS funds become the property of the client and the client **is not** obligated to return the property upon leaving the program.

However, there may be clinical situations in which a provider and client make an agreement for the client to reimburse the provider for the services/supports, including the payment of rent that the provider purchased on the client/family/caregiver's behalf.

SUBMISSION OF REIMBURSEMENT DOCUMENTS:

The Department expects its contractors to exercise responsible accounting practices and ensure that expense claims are submitted in a timely manner.

Contractor shall itemize the expenses claimed on the CSS Expense Reimbursement Claim Form, hide the Protected Health Information (PHI) in the Excel spread sheet and submit to the Provider Reimbursement Unit (PRU) within 60 days of the end of the month in which the expense was incurred. PRU will log in and forward to appropriate Age Group Lead/designee.

To expedite processing it is suggested the contractor simultaneously submit the same Claim Form with PHI visible to appropriate Age Group Lead/designee.

Failure to submit claims on a regular basis impedes the efficiency of the reimbursement process significantly. Claims that are not submitted in a timely manner each month may be subject to delays

in review and payment. After a reimbursement claim for a month has been submitted, any additional expense claims for a month shall be submitted on a separate reimbursement claim form.

REFERENCES: DMH Client Supportive Services Service Exhibit

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

CLIENT SUPPORT SERVICES (CSS) EXPENDITURE CODING GUIDE

CSS funding is for use when clients do not have resources and other possible avenues for funding have been explored and exhausted. Listed below is a general guideline for coding common expenses with the appropriate matching Service Function Codes (SFCs). It is important to remember that individual expenses are unique to each client and are not necessarily limited to those listed in the categories below.

ALLOWABLE EXPENSES

SFC 70 – CLIENT HOUSING SUPPORT

- Eviction Prevention, i.e. payment of overdue rent
- Hotel/Shelter Subsidies
- Master Leasing (with DMH approval)
- Rent/Mortgage/Lease Subsidies (e.g. apartments, Sober Living Homes, Adult Residential Facilities)
- Residential substance abuse treatment programs
- Security Deposits
- Transitional Residential Programs

SFC 71 – CLIENT HOUSING OPERATING SUPPORT

- Agency Management Fees
- Credit Reporting Fees
- Insurance
- Property Taxes
- Repair/Maintenance to Home, including repair due to damage by tenant
- Utilities, e.g. electricity, gas, water

SFC 72 – CLIENT/FAMILY/CAREGIVER SUPPORT

- Car, e.g. gasoline, insurance, payment, registration, repair
- Clothing
- Culturally appropriate alternative healing methods, e.g. curandero, cupping, acupuncture
- Education and Tutorial Expenses
- Employment , e.g. uniforms, license fees, tools of the trade

SFC 72 – CLIENT/FAMILY/CAREGIVER SUPPORT (CONTINUED)

- Food
- Furniture/Appliances
- Gift Cards
- Household Items, e.g. Kitchenware, Linen/Bedding, Cleaning Products
- Hygiene Items
- Medical/ Dental/ Optical
- Moving Expenses
- Recreational/Social Activities
- Reinforcers i.e., Inexpensive, small primary reinforcers for behavioral management purposes linked directly to client service plans
- Respite Care
- School Supplies
- Sports Registration
- Summer Camps
- Tickets/citations – *REQUIRE PRE-AUTHORIZATION FROM AGE GROUP LEAD*
- Transportation, e.g. Bus Passes, Tokens, Taxi Vouchers
- Vocational

SFC 78 – OTHER NON-MEDI-CAL CLIENT SUPPORT

- Consumer/Peer/Parent Advocate Salaries*
- Housing/Employment Specialists Salaries*

**Members of the program's treatment team that bill through the IS cannot request their wages be reimbursed through this mechanism. See Guideline for details.*

NON–ALLOWABLE EXPENSES

- Alcohol
- Construction or rehabilitation of housing, facilities, buildings or offices
- Costs for staff to accompany clients to venues such as sporting events, concerts or amusement parks
- Expenses related to purchasing land or buildings
- Illegal substances / activities
- Incentives
- Medi-Cal Share of Cost
- Prescription drugs that would otherwise be available via Indigent Medication / Prescription Assistance programs
- Service Extenders/Wellness Outreach Workers (WOW)
- Sexually explicit materials
- Tobacco
- Units of Service or any other service costs that are reported under Modes 05, 10, 15, or 45
- Vehicles for programs

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

REASONABLE AND ALLOWABLE PURCHASE LIMITS

Client Support Services (CSS) funding is for use when clients do not have the resources and when other possible avenues for funding have been explored and exhausted. Listed below is a general guideline for coding common expenses with the appropriate matching Service Function Code (SFCs). Individual expenses are unique to each client and are not necessarily limited to the categories listed below. Please submit a pre-approval Supplemental Information Request (SIR) form if the purchase exceeds these limits.

SFC 70 – CLIENT HOUSING SUPPORT

Shelter	$300 Monthly
Motel or Hotels	$50 - $100 per night (pre-approval required for stays over 5 nights)

Rent (Fair Market Rent) or Board & Care Rates (adults) with pre-approval

Efficiency	1 bedroom	2 bedroom	3 bedroom	4 bedroom
$1,350	$1,750	$2,550	$3,250	$3,400

Rent of residence (per person)	$315 per month*
Security Deposits	2 times the monthly rent, unfurnished
	3 times the monthly rent, furnished

*Rents may vary depending upon location and fair market Value of housing

SFC 71 – CLIENT HOUSING OPERATING SUPPORT

Credit Reporting Fees	$15-$20 per report
Property Tax	$3,000 (pre-approval by age group lead required)
Utilities	Water & Electricity, $130 - $150 per month
	Cell phone: pre-paid up to $50 per month
	monthly up to $100 per month
	Gas, $30 - $50 per month
Basic Cable	$30 per month
Internet	$42 per month
Bundle[I]	TV/Telephone, $60 - $80 per month
	TV/Telephone/Internet, $105 per month

SFC 72 – CLIENT/FAMILY/CAREGIVER SUPPORT

Car gasoline	$300 per month
Clothing	$150 per person, per month (including tax)
Shoes	$60 per person, per month (including tax)
Alternative Healing Methods	Curandero, $40 - $100 per session
	Acupuncture $70 - $120 per session
Food	$250 per person, per month (including tax)
Household Items	$95 per month (including tax)
Hygiene Items	$90 per month (including tax)
Recreation/Social Activities	$135 per month
Summer Camp[II]	$75 - $350 per week; up to $700 per month
School Supplies	$50 monthly per month, per client (including tax)
Private Tutor	$20/hr. - $50/hr. (maximum of $600 a month)
Learning Centers	$15/hr. - $25/hr. (maximum of $500 a month)
Transportation	$100 monthly Metro Pass
	Up to $57.50 (30 tokens) monthly per client
Household Goods[III]	Up to $2500 (including tax)
	*Purchases must not exceed the $2500 maximum for all combined items
Appliances	Stove, $450-$600 (New) (including tax & delivery)
	Washer/Dryer, $200 - $1000 (including tax and delivery)
	Refrigerator, up to $600 (including tax & delivery)
	Microwave, up to $60 (including tax)
	Television, up to $400 (including tax & delivery)
	Vacuum Cleaner, up to $120 (including tax & delivery)
Bedroom Furniture	$400 (including tax & delivery)
Mattresses	$450 (including tax & delivery)
Living Room Furniture	$550 (including tax & delivery)
Kitchen/Dining Table Set	$200-$300 (including tax & delivery)
Immigration Assistance Fees[IV]	$400 - $1000

Exceptions to these guidelines may be made on a case by case basis with pre-approval by the Age Group Lead

[I] Bundle services will vary depending on the carrier. Certain residences can only subscribe to a specific carrier.

[II] Monthly cost depends upon duration of program and scope of services.

[III] Household goods include appliances, furniture, kitchenware and linens.

[IV] Attached is a summary of fees associated with form number.

County of Los Angeles-Department of Mental Health-Provider Reimbursement Division
Monthly Claim for Cost Reimbursement

Fiscal Year _____

INVOICE NUMBER: _____

Client Supportive Services and One-Time MHSA Expenses

Funding Source Name: _____ **Age Group:** _____

For Innovation: INN MODEL: □ ICM □ IMHT □ ISM □ PEER RUN

Legal Entity Name: _____

Legal Entity Mailing Address: _____

Billing Month(s): _____ Contract Amendment No.: _____

Provider Number(s): _____

1. Expenditures:
   - 1.1 A. SFC 70: Client Housing Support Expenditures _____ (1.1)
   - 1.2 B. SFC 71: Client Housing Operating Expenditures _____ (1.2)
   - 1.3 C. SFC 72: Client Flexible Support Expenditures _____ (1.3)
   - 1.4 D. SFC 75: Non-Medi-Cal Capital Assets _____ (1.4)
   - 1.5 E. SFC 78: Other Non Medi-Cal Client Support Expenditures _____ (1.5)
2. One-Time Costs:
   - 2.1 A. SFC 72: Client Flexible Support Expenditures _____ (2.1)
   - 2.2 B. SFC 75: Non Medi-Cal Capital Assets _____ (2.2)
     One-time Assets >$5000
   - 2.3 C. SFC 78: Other Non Medi-Cal Client Support Expenditures _____ (2.3)
     One-time Recruitment, Training, and Equipment <$5000
3. Total Expenditures (add lines 1.1 through 2.3) _____ (3.0)

   Less: Patient & Third Party Revenues
   - 3.1 Patient Fees _____ (3.1)
   - 3.2 Patient Insurance _____ (3.2)
   - 3.3 Medicare _____ (3.3)
   - 3.4 Other: _____ _____ (3.4)
4. Total Revenues (add lines 3.1 through 3.4) _____ (4.)
5. Expenditures less revenues (subtract line 4 from line 3) _____ (5.)
6. **Net Payable** _____ (6.)

Comments: _____

***NOTE*: CAPITAL DEVELOPMENT PROJECTS, INCLUDING ALL FIXED ASSETS OR REAL ESTATE ACQUISITIONS PURCHASED WITHIN THE PARAMETERS OF CLIENT SUPPORTIVE SERVICES, REQUIRE THE DIRECTOR'S PRIOR APPROVAL.**

I hereby certify that all information contained above are services and costs eligible under the terms and conditions for reimbursement under Client Supportive Services and is true and correct to the best of my knowledge. All supporting documentation will be maintained in a separate file for the period specified under the provisions of the Mental Health Services Agreement - Legal Entity, Paragraph 12, Subparagraph A, Section (1), Sub-sections (1)(a) and (1)(b), Section (2), Section (3), and Section (4).

Signature: _____ Phone No.: _____

Title: _____ Date: _____

LAC-DMH Program Approval:

_____ _____
Approved By (signature) Date

_____ _____
Print Name Title

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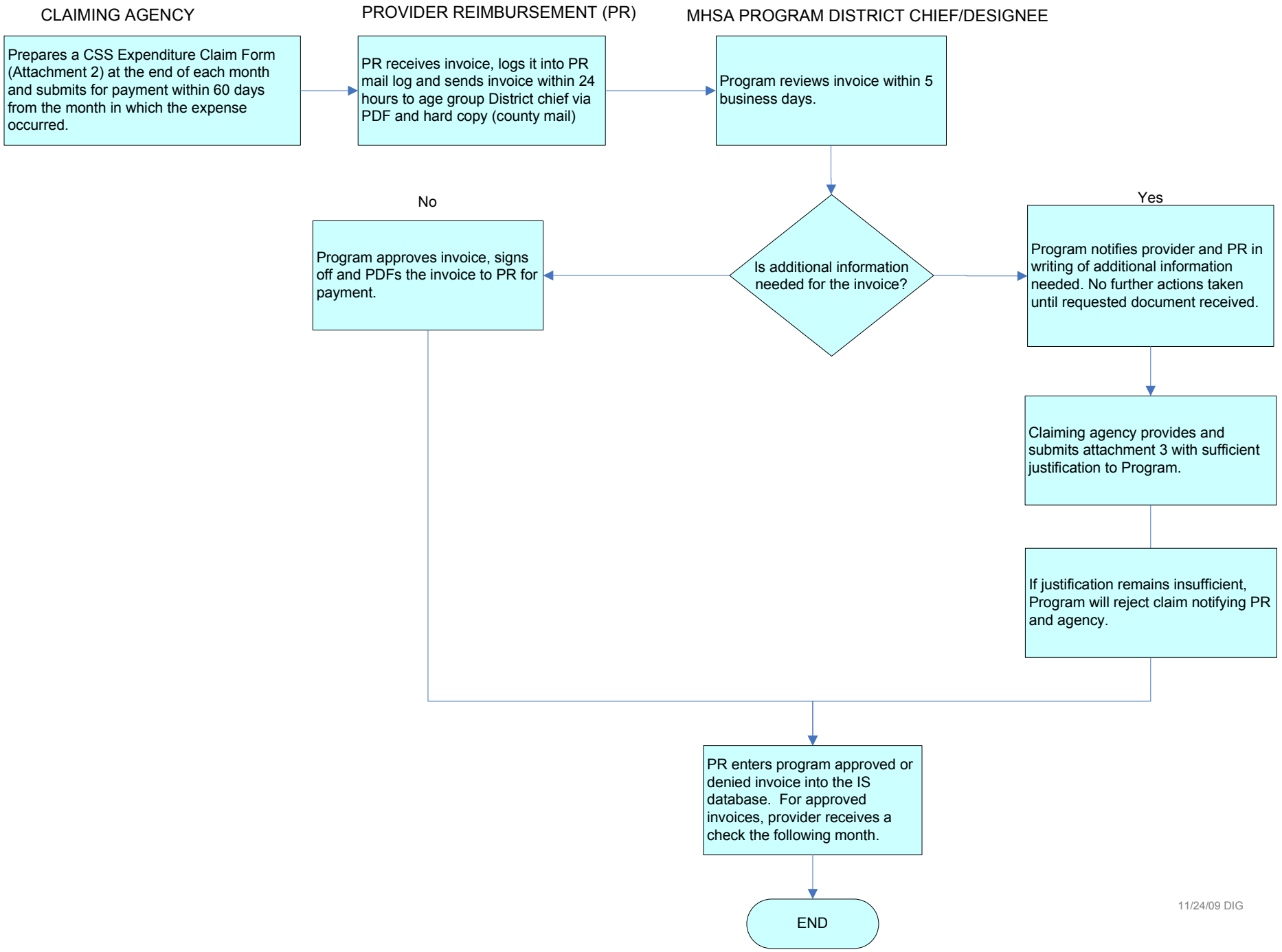
COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

CSS EXPENSE CLAIM PROCESSING FLOW CHART



11/24/09 DIG

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CSS EXPENSE REIMBURSEMENT CLAIM

TYPE OF CSS FUNDS: ☐ **FCCS** ☐ **FSP** ☐ **Wellness** ☐ **INN** **Age Group/INN Model:** _____ **Fiscal Year:** _____

Legal Entity Number: _____ **Billing Month:** _____

Legal Entity Name: _____ **Provider Number:** _____

*See attached table for common Service Function Codings

IS#	Client Name	Vendor	Description	*SFC 70	*SFC 71	*SFC 72	*SFC 78
			Totals:				

TOTAL REIMBURSEMENT:

Agency Verification

I hereby certify that all information contained above are services and costs eligible under the terms and conditions for reimbursement under Client Support Services and is true and correct to the best of my knowledge. All supporting documentation will be maintained in a separate file for the period specified under the provisions of the Mental Health Services Agreement - Legal Entity, Paragraph 13, Subparagraph A, Section (1), Sub-sections (1)(a) and (1)(b), Section (2), Section (3), and Section (4).

Signature _____ Date _____

Print Name _____ Title _____

DMH APPROVAL

Date _____ Signature _____

Print Name _____ Title _____

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COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

Attachment 2

CLIENT SUPPORTIVE SERVICES (CSS) EXPENSE REIMBURSEMENT CLAIM

Type of CSS Funds: ☐ **RRR** ☐ **FSP** ☐ **INN**

***Program Type:** ____________________

Legal Entity Number : ____________________

Billing Month: __________ **Fiscal Year:** __________

Legal Entity Name: ____________________

Provider Number: __________

*See attached table for common Service Function Codings

IS #	Client Name	Vendor	Description	*SFC 70	*SFC 71	*SFC 72	*SFC 78
			Totals:				

*** Please identify the specific program for each type of CSS funding. Examples include, but are not limited to Child FSP, IFCCS, Wrap Child, TAY FSP, Wrap TAY, Adult FSP, IMHT, AOT, Older Adult FSP, Homeless, Housing, IC, ISM, etc.**

TOTAL REIMBURSEMENT:

Agency Verification

I hereby certify that all information contained above are services and costs eligible under the terms and conditions for reimbursement under Client Support Services and is true and correct to the best of my knowledge. All supporting documentation will be maintained in a separate file for the period specified under the provisions of the Mental Health Services Agreement - Legal Entity, Paragraph 13, Subparagraph A, Section (1), Sub-sections (1)(a) and (1)(b), Section (2), Section (3), and Section (4).

Signature ____________________ Date ____________________

Print Name ____________________ Title ____________________

DMH APPROVAL

Date ____________________ Signature ____________________

Print Name ____________________ Title ____________________

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SUPPLEMENTAL INFORMATION REQUEST FORM

REQUEST / RECIPIENT INFO

Agency Name: _____ Provider #: _____ Date: _____

Name of person requesting funds: _____ Title: _____ Billing Month: _____

Name of CSS Fund recipient: _____ IS #: _____

Amount Requested: $ _____ Have CSS Funds been requested for this person before? Y _____ N _____

CSS FUND USAGE DETAIL

Description of purchase: _____

Purpose of purchase: _____

_____

How does purchase support and contribute to client's treatment goals (attach CCCP) _____

_____

For expenses of 3 or more months or 6 or more months of duration (refer to page 1 of policy): _____

_____

_____

List alternative resources explored to cover expense:

_____

VERIFICATION

I hereby certify that all of the information contained above is true and accurate to the best of my knowledge.

Print Case Manager's Name	Case Manager's Signature	Date

Print Approving Manager's Name	Approving Manager's Signature	Date

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
FULL SERVICE PARTNERSHIP (FSP) GUIDELINES

DMH CONTACTS

Service Area & Supervisors	Children (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60 +)
1 **Cindy Ferguson** **(661) 223-3842**	**Salem Redding** Ph: (661) 223-3816 BB: (213) 494-8123 Fx: (661) 537-2937	**Salem Redding** Ph: (661) 223-3816 BB: (213) 494-8123 Fx: (661) 537-2937	**Angela Coleman** Ph: (661) 223-3813 Fx: (661) 537-2937	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492
2 **Michelle Rittel (Child)** **(213) 739-5526** **La Tina Jackson (Adult)** **(818) 610-6708**	**Luz Smith** Ph: (818) 610-6739 Fx: (818) 347-8738 **Fang (Colin) Xie** Ph:(818) 610-6729 Fx: (818) 347-8738	**Terica Roberts** Ph:(213) 923-6459 Fx: (818) 347-8738	**Darrell Scholte** Ph: (818) 610-6705 Fx: (818) 347-8736 **Michele Renfrow** Ph: (818) 610-6724 Fx: (818) 347-8736	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492
3 **Frances Liese (Child & TAY)** **(626) 430-2914** **Eugene Marquez (Adult)** **(626) 430-2915**	**Isabel Banuelos (interim)** Ph: (626) 430-2950	**Socorro Ramos** Ph: (626) 430-2949	**Eugene Marquez** Ph: (626) 430-2915	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492
4 **Nancy Weiner** **(213) 922-8120** **Navigator Main Number** **(213) 922-8122**	**Suyapa Umanzor** Ph: (213) 922-8123 Fx: (213) 680-3225	**Christina Padilla** Ph: (213) 922-8132 Fx: (213) 680-3225 **Kimberly Williams (temp)** Ph: (213) 922-8132	**Phyllis Moore-Hayes** Ph: (213) 922-8129 Fx: (213) 680-3225	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492
5 **Monika Johnson (Child &TAY)** **(310) 482-6609** **Gwendolyn Davis (Adult)** **(310) 482-6613**	**Jeong Min Rhee** Ph: (310)482-6610 Fx: (310)313-0813	**Jeong Min Rhee** Ph: (310)482-6610 Fx: (310)313-0813	**Samantha Howard** Ph: (310) 482-6612 Fx: (310) 313-0813 **Kim Phan** (310) 482-6616	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492
6 **Yolanda Whittington** **(213) 738-3779**	**Margarita Cabrera** Ph: (213) 738-2425 Fx: (213) 351-7747	**Jasminder Chahal** Ph: (213) 435-3362 Fx: (562) 929-4540	**Perla Cabrera** Ph: (213) 738-3313 Fx: (213) 351-7747	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492
7 **Jessica Ahearn** **(213) 639-6733**	**Cheryl Lopez** Ph: (213) 738-2900 Fx: (213) 384-0729	**Cheryl Lopez** Ph: (213) 738-2900 Fx: (213) 384-0729	**Alicia Ibarra** Ph: (213) 738-6150 Fx: (213) 384-0729	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492
8 **Chad Brinderson** **(213) 276-5503** **Main:** **562-256-7717**	**April Hagerty** Ph: (562) 256-1280 Fx: (562) 290-1230	**Emily Serna** Ph: (562) 256-1277 Fx: (562) 290-1230	**Jenny Nguyen** Ph: (562) 256-1278 Fx: (562) 290-1230 **Trisha Deeter** Ph: (562) 256-1279 Fx: (562) 290-1230	**Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492 **Jenny Nguyen** Ph: (562) 256-1278
Countywide Authorization Contact	**CSOC** **Rebeca Hurtado** Ph: (213) 739-5491 Fx: (213) 252-0238	**TAY** **Karen Mooney** Ph: (213) 738-2027 Fx: (213) 351-6571	**ASOC** **Dennis Griffin** Ph: (213) 639-6734 Fx: (213) 427-6178	**OASOC** **Eliette Montiel** Ph: (213) 738-2127 Fx: (213) 738-3492

XII. FORMS

A. Community Outreach Services

B. Referral and Authorization/Notification
   1. Children (ages 0-15)
   2. Transition-age Youth (ages 16-25)
   3. Adult (ages 26-59)
   4. Older Adult (ages 60+)

C. Appeal (Related to Enrollment, Disenrollment and Transfer)

D. Authorization for Use or Disclosure of Protected Health Information

E. Disenrollment Request

F. Transfer Request

G. Disenrollment/Transfer Request Supplemental

H. Reinstatement Authorization Form

Print Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

COMMUNITY OUTREACH SERVICES

CONFIDENTIAL CLIENT INFORMATION CALIFORNIA WELFARE & INSTITUTIONS CODE SEC 5238

PROVIDER #:	**DATE OF SERVICE:**	**RENDERING PROVIDER:**
SERVICE RECIPIENT TYPE:		**# OF PERSONS CONTACTED:**
SERVICE LOCATION INFORMATION ENTER AGENCY SERVICE RECIPIENT AND ACTIVITIY INFORMATION BELOW	SERVICE TYPE DESC:	
AGENCY NAME:		ADDRESS:
AGENCY CONTACT:	PHONE #:	CITY / STATE / ZIP:

PLEASE ENTER CODE TO INDICATE PREDOMINANT ETHNICITY AGE RANGE AND LANGUAGE OF TARGET GROUP

PRIMARY LANGUAGE:	**ETHNICITY:**	**If Hispanic, indicate Origin:**	**If American Indian/Alaska Native, Indicate Tribe:**
AGE CATEGORY:	**DURATION:** (FMI - Fifteen Min. Increment)	**HANDICAP:**	**PROGRAM AREA:**
FUNDING SOURCE:			
SERVICE CODE:			
ADDITIONAL PARTICIPATING STAFF:			

CERTIFICATION OF CONSULTANT

I CERTIFY THAT THE ABOVE COMMUNITY OUTREACH SERVICES WERE PROVIDED AS DOCUMENTED.

SIGNATURE: _____ DATE: _____

COS Form Fillable v4
Rev. 7/1/2010 ET

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

COMMUNITY OUTREACH SERVICES

CONFIDENTIAL CLIENT INFORMATION CALIFORNIA WELFARE & INSTITUTIONS CODE SEC.5238

PROGRESS NOTES/FUTURE PLANS/RECOMMENDATIONS

PROGRESS NOTES: (Include presenting problems, goals, content, process and outcome)

FUTURE PLANS/RECOMMENDATIONS: (Include major topics or problem areas to be addressed and any special problems or successful techniques which might be helpful in the future consultation)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

INTENSIVE MENTAL HEALTH SERVICES REFERRAL FORM

DEMOGRAPHIC INFORMATION

Child/youth is being referred to: ☐ FSP (ages 0-15) ☐ IFCCS (ages 0-21)

Referral Date: _____ **IS / IBHIS #:** _____

SSN: _____

Last Name: _____ **First Name:** _____ **Gender:** _____

Preferred Language _____ **Ethnicity:** _____ **DOB:** _____ **Age:** ____

Insurance: ☐ Medi-Cal ☐ Indigent/None ☐ Third Party Payor

Current Living Situation: ☐ Home of Parent ☐ Relative ☐ Foster Home ☐ ESC ☐ TSC

☐ Group Home Facility Name: _____ Level: _____ ☐ Other: _____

Current Address: _____

City: _____ **Zip Code:** _____ **Phone:** _____

Primary Contact: _____ **Relationship:** _____

Primary Contact's Preferred Language: _____ **Phone:** _____

Conservator? ☐ No ☐ Yes **Name:** _____ **Phone:** _____

REFERRAL SOURCE

Contact Person: _____ **Agency:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

If you are an IFCCS Referral Portal, please identify your portal:

☐ Child/TAY ☐ CYCS Team (SB 82) ☐ DCFS High Risk Unit ☐ DMH D-Rate Assessment

☐ DMH Hospital D/C Unit ☐ DMH MAT ☐ DMH Wrap Liaison ☐ EOB

☐ Medical HUB ☐ SFC ☐ TSC ☐ UCC/Valley Coordinated

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ Regional Center

Please identify recent referrals: ☐ D-Rate ☐ Wraparound ☐ RCL 12 or above ☐ TFC ☐ Other: _____

☐ **Child/Family is aware a referral has been submitted to an intensive mental health program**

This confidential information is provided to you in accord 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. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DCFS INFORMATION

Individual's Name: _____

IS/IBHIS #: _____

DCFS Case: ☐ Adoption ☐ ER Case ☐ Family Maintainence/Reunification

☐ New Detention ☐ Voluntary Case

Assigned DCFS Office: _____

CSW Name: _____ **Phone:** _____ **E-mail:** _____

SCSW Name: _____ **Phone:** _____ **E-mail:** _____

If you are a DCFS referring party, please attach the following documents:

☐ Child Profile Report

☐ Consents (179)/Minute ☐ Court Report/Voluntary Case Report ☐ JV 220 (current) ☐ Placement History

LEVEL OF SERVICE

Check ONE ONLY:

☐ Unserved (Not receiving mental health services)

☐ Historv of mental health services, but none ☐ No prior mental health services

☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*

☐ PEI ☐ FCCS ☐ Outpatient ☐ Other: _____

☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

If client is currently receiving mental health services please indicate:

Therapist: _____ Agency: _____ Phone: _____

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

DIAGNOSTIC CONSIDERATIONS

Primary DSM-5 Diagnosis: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

☐ Aggressive Acts (by history or current)
☐ Aggressive Ideation/Threats (by history or current)
☐ Contact with PMRT or Urgent Care
☐ Eating Disturbances
☐ Exposure to Trauma
☐ Fire Setting Ideations or Acts
☐ Hyperactive/Impulsive/Inattentive
☐ Psychiatric Hospitalization (indicate dates below)
☐ Suicidal Ideations/Attempts
☐ Symptoms of Psychosis
☐ Tarasoff Notifications (past or current)
☐ Other: _____

Provide details for any checked items:

FOCAL POPULATION

Individual's Name: _____

IS/IBHIS #: _____

CHECK APPROPRIATE REASON(S) FOR REFERRAL OF A CHILD OR YOUTH (AGE 0 - 21) WHO HAS A SERIOUS EMOTIONAL DISTURBANCE (SED)* AND AT LEAST ONE OF THE FOLLOWING:

1. Zero to five-year-old who:
   - ☐ is at risk of expulsion from pre-school
   - ☐ is at risk of removal or has been removed from the home by the Department of Children and Family Services (DCFS)
   - ☐ has a parent/caregiver with severe and persistent mental illness, or who has a substance abuse co-occurring disorder

2. Child/youth who:
   - ☐ has been removed or is at risk of removal from the home by DCFS
   - ☐ has a history of drug possession or use
   - ☐ is at risk of or currently involved with the juvenile justice system
   - ☐ is at risk of commercial sexual exploitation
   - ☐ is currently a victim of commercial sexual exploitation
   - ☐ has had three or more DCFS placements within the past 24 months

3. Child/youth unable to function in the home and/or community setting and:
   - ☐ is transitioning back to a less structured home or community setting
   - ☐ is at risk of becoming or is currently homeless

4. Child/youth experiencing the following at school:
   - ☐ truancy or sporadic attendance
   - ☐ suspension or expulsion
   - ☐ failing classes

Provide Detail for Any Checked Items:

*"Seriously emotionally disturbed" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either if the following occur:
   (i) The child is at risk of removal from home or has already been removed from the home.
   (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment. treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. [California Welfare and Institutions Code Section 5600.3]

If referring to FSP, fax completed Referral and Authorization Form to your Service Area **Impact Unit** :

SA 1: Salem Redding	(661) 537-2937	SA 4: Suyapa Umanzor	(213) 680-3225	SA 8: April Hagerty	(562) 290-1230
SA 2: Colin (Fang) Xie	(818) 347-8738	SA 5: Jeong Min Rhee	(310) 313-0813		
Luz Smith		SA 6: Dana Calloway	(213) 351-7747		
SA 3: Vanessa Torres	(626) 331-0121	SA 7: Cheryl Lopez	(213) 384-0729		

If referring to IFCCS, email completed Referral and Authorization Form to **CSOCIFCCS@dmh.lacounty.gov**

This confidential information is provided to you in accord 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. Destruction of this information is required after the stated purpose of the original request is fulfilled.

FSP DISPOSITION

Individual's Name _____

IS/IBHIS #: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT:** Explain reason for decision and plan for linkage to other services)

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider #: _____

FSP Agency Address: _____ City: _____ ZIP Code: _____

Contact Person: _____ Phone: (____) _____

Service Area: ____ Supervisorial District: _____ Fax: (____) _____

Impact Unit Representative: _____ **Date:** _____

TO BE COMPLETED BY FSP AGENCY

(Referral and Authorization Form must be submitted to **Impact Unit** for your Service Area through SRTS)

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL** **Intake Date :** _____

☐ **AGENCY DECLINES TO ENROLL, BUT THE INDIVIDUAL IS ELIGIBLE FOR** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES AND NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOT AUTHORIZED FOR ENROLLMENT**

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

Previous FSP/ IFCCS / Wraparound Enrollment Within 365 Days: ☐ YES ☐ NO

Previous Agency Name: _____

Program: ☐ FSP ☐ IFCCS ☐ Wraparound

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ by _____

Date **Impact Unit Representative**

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IFCCS DISPOSITION

Individual's Name: _____

IS/IBHIS #: _____

TO BE COMPLETED BY CSOC ADMINISTRATION

Date Received: _____

Reviewed By: _____

☐ **ASSIGNED**

Agency Assigned To: _____ Date: _____

Previous FSP/ IFCCS / Wraparound Enrollment Within 365 Days: ☐ YES ☐ NO

Previous Agency Name: _____

Program: ☐ FSP ☐ IFCCS ☐ Wraparound

☐ **NOT ASSIGNED**

Reason:

Linkage:

Provider #: _____

Agency Address: _____ City: _____ Zip Code: _____

Contact Person: _____ Phone: _____

Service Area: _____ Supervisorial District: _____ Fax: _____

Date of First Face-to-Face Contact: _____

Please check one of the following:

☐ **Has Been Enrolled in IFCCS** **Intake Date:** _____

☐ **Not Enrolled in IFCCS (Please select one of the following):**

☐ **Does Not Agree to IFCCS**

(Explain reason for decision and plan for linkage to other services)

☐ **Deemed Ineligible for IFCCS**

(Explain reason for decision and plan for linkage to other services)

☐ **Other**

(Please specify):

Agency Representative: _____ **Date**: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

TRANSITION AGE YOUTH (TAY) (16-25)
FULL SERVICE PARTNERSHIP
REFERRAL AND NOTIFICATION FORM

REFERRAL INFORMATION

***Insufficient details may delay referral process**

DMH IS/IBHIS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **UNKNOWN**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **HEALTHY FAMILIES** ☐ **HEALTHY KIDS** ☐ **PRIVATE** ☐ **NONE**

BENEFITS: ☐ **GR RECIPIENT** ☐ **V.A.** ☐ **SSI** ☐ **SSDI** ☐ **OTHER INCOME**

☐ **CLIENT SERVED IN THE MILITARY**

PRIMARY CONTACT: _____ **RELATIONSHIP:** _____

PREFERRED LANGUAGE: _____ **PHONE:** (____) _____

CONSERVATOR ? ☐ **YES** ☐ **NO** **NAME:** _____ **PHONE:** (____) _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ DMH ☐ Regional Center Parole: ☐ Revocable* ☐ Non-Recovable

If Individual was referred to any other programs, please identify: _____

☐ Client is aware client has been referred to the FSP Program * Client is not eligible for services

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LEVEL OF SERVICE

Individual's Name: _____

DMH IS/IBHIS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ Recovery, Resilience & Reintegration Services ☐ PEI ☐ Other: _____
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **ICD-10 Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatrica Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)
- ☐ Other _____

Provide Detail for Any Checked Items: _____

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit** for your Service Area:

SA 1: Salem Redding	(661) 537-2937	SA 4: Christina Padilla	(213) 680-3225	SA 7: Cheryl Lopez	(213) 384-0729
SA 2: Terica Roberts	(818) 347-8738	SA 5: Jeong Min Rhee	(310) 313-0813	SA 8: Emily Serna	(562) 290-1230
SA 3: Socorro Ramos	(626) 331-0058	SA 6: Jasminder Chahal	(562) 929-4540		

FOCAL POPULATION

Individual's Name: _____

DMH IS/IBHIS#: _____

Check either A. or B.

If the client meets the focal population for section A., the referral requires authorization.

If the client meets the focal population for section B., the referral is considered a notification.

In the event the client meets the criteria for both A. and B., the referral requires authorization.

A. ☐ **AUTHORIZATION FOR ENROLLMENT**

B. ☐ **NOTIFICATION FOR ENROLLMENT** **ENROLLMENT DATE:** _____

TAY must have a Serious Emotional Distubance (SED)* and/or Severe and Persistent Mental Illness (SPMI)**

A. CHECK APPROPRIATE REASON(S) FOR REFERRAL:

1. ☐ Youth aging out of:
   ☐ Child Mental Health System ☐ Child Welfare System ☐ Juvenile Justice System
2. ☐ Youth leaving Long-term Institutional Care
   ☐ Level 12-14 Group Homes ☐ Community Treatment Facility (CTF) ☐ Jail
   ☐ Institution of Mental Disease (IMD) ☐ State Hospital ☐ Probation Camps
   Estimated Discharge Date: _____
3. ☐ Youth experiencing their first psychotic break
4. ☐ Co-Occurring Substance Abuse Disorder **in addition** to meeting at least one (checked) TAY focal population criteria identified above.
5. ☐ Homeless (Indicate current living situation): _____
   ☐ Chronically Homeless (HUD Standards)***

Provide Detail for Any Checked Items:

_____

_____

_____

B. CHECK APPROPRIATE REASON(S) FOR NOTIFICATION:

1. ☐ At risk of homelessness: unstable, sporadic housing/multiple placements
2. ☐ Currently a victim of commercial sexual exploitation
3. ☐ Youth with a history of commercial sexual exploitation

* (SED) "Seriously emotionally disturbed" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. [California Welfare and Institutions Code Section 5600.3]

** (**SPMI)** For TAY ages 16-25 may include significant functional impairment in one or more major areas of functioning (e.g., interpersonal relations, emotional, vocational, educational, or self-care) for at least 6 months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

*** **Chronic Homeless HUD**: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has had 4 episodes of homelessness in the past three years.

DISPOSITION

Individual's Name: _____

DMH IS/IBHIS#: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: _____

Service Area: _____ Supervisorial District: _____ Fax: _____

Impact Unit Representative: _____ **Date:** _____

(**Fax** completed Referral and Authorization Form to **Impact Unit** for your Service Area)

TO BE COMPLETED BY FSP AGENCY

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL**

☐ **AGENCY DECLINES TO ENROLL, BUT INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP SERVICES** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES *AND* NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOTIFICATION ACKNOWLEDGED Date:** _____

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

PREVIOUS FSP ENROLLMENT WITHIN 365 DAYS ☐ **YES** ☐ **NO** **AGENCY** _____

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ (Date) by _____ (Impact Unit Representative)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

ADULTS (AGES 26-59) & FORENSIC FULL SERVICE PARTNERSHIP AUTHORIZATION/NOTIFICATION FORM

CLIENT INFORMATION

FSP PROGRAM: (check one)

- ☐ ADULT
- ☐ FORENSIC

***Insufficient details may delay referral process**

DMH IS/IBHIS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY:** _____ **GENDER:** ☐ M ☐ F ☐ OTHER

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ MEDI-CAL ☐ MEDICARE ☐ NONE ☐ PRIVATE: _____

BENEFITS: ☐ GR RECIPIENT ☐ V.A. ☐ SSI ☐ SSDI ☐ OTHER INCOME:

☐ CLIENT SERVED IN THE MILITARY **CONSERVATOR?** ☐ YES ☐ NO **NAME:** _____

PHONE: ( ) _____

PRIMARY CONTACT: _____ **PHONE:** ( ) _____

RELATIONSHIP: _____

REFERRAL SOURCE

Agency: _____ Provider # (if applicable): _____ Service Area: _____

Contact Person: _____ Phone: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ Probation ☐ APS ☐ GR/DPSS ☐ Parole: ☐ Revocable (Client is not eligible for services) ☐ Non-Revocable

If Individual was referred to any other programs, please identify: _____

FSP Agency Representative: _____

☐ Client is aware that an FSP referral has been made on his/her behalf.

FOCAL POPULATION

Individual's Name: _____

DMH IS/IBHIS#: _____

Check either A. or B.

If the client meets the focal population for section A., the referral requires authorization.
If the client meets the focal population for section B., the referral is considered a notification.
In the event the client meets the criteria for both A. and B., the referral requires authorization.

A. ☐ **AUTHORIZATION FOR ENROLLMENT**
B. ☐ **NOTIFICATION FOR ENROLLMENT** **ENROLLMENT DATE:** _____

A. CHECK APPROPRIATE REASON(S) FOR REFERRAL:

	# Days during last 12 months	# Episodes in last 12 months
☐ Homeless ☐ [1]Chronically Homeless (HUD Standards)		
☐ Jail		
☐ Institution(s) (mark all that apply):		
☐ Institution for Mental Disease		
☐ State Hospital		
☐ Psychiatric Emergency Services		
☐ Urgent Care Center		
☐ County Hospital		
☐ Fee for Service Hospital		

Name of Acute/Long Term Psychiatric Facilities: _____

☐ Living with family members without whose support the individual should be at Imminent Risk of Homelessness, jail or institutionalization.
Specify: _____

Document any pertinent outreach information regarding client here: (Ex. Client is difficult to engage, client prefers female staff, language barriers, etc.)

B. CHECK APPROPRIATE REASON(S) FOR NOTIFICATION: **ENROLLMENT DATE:** _____

☐ At risk of becoming homeless (History of destruction of property, unable to maintain living arrangement, ongoing conflict with neighbors and/or landlord, etc.)
☐ At risk of becoming involved with the criminal justice system (Unable to pay fees, presence of warrants, two or more contacts with law enforcement in the past 90 days, etc.)
☐ At risk of being psychiatrically hospitalized (Two or more visits to a psychiatric urgent care center, medical emergency room for a psychiatric disorder, or psychiatric emergency room in the past 90 days or at least one encounter with an emergency outreach team in the past 90 days, etc.)

Provide additional details

[1]Chronic Homeless HUD: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has 4 episodes of homelessness in the past three years.

LEVEL OF SERVICE

Individual's Name: _____

DMH IS/IBHIS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ Recovery, Resilience & Reintegration Services ☐ PEI ☐ Other: _____
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

DSM-5/ICD-10 Code: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Other _____
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatric Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)

Provide Detail for Any Checked Items:

_____

_____

_____

Fax completed Pre-Authorization/Notification Form to **Impact Unit** for your Service Area:

SA 1: Angela Coleman	(661) 537-2937	SA 5: Kim Phan	(310) 313-0813	SA 8: Trisha Deeter	(562) 290-1230
SA 2: Darrell Scholte	(818) 347-8736	SA 5: Samantha Howard	(310) 313-0813	SA 8: Jenny Nguyen	((562) 290-1230
SA 3: Eugene Marquez	(626) 331-0121	SA 6: Perla Cabrera	(213) 351-7747		
SA 4: Phyllis Moore Hayes	(213) 680-3225	SA 7: Alicia Ibarra	(213) 384-0729		

DISPOSITION

Individual's Name: _____

DMH IS/IBHIS#: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: (____) _____

Service Area: _____ Supervisorial District: _____ Fax: (____) _____

Impact Unit Representative: _____ **Date:** _____

(Fax completed Referral Form to **Impact Unit** for your Service Area)

TO BE COMPLETED BY FSP AGENCY

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL**

☐ **AGENCY DECLINES TO ENROLL, BUT INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP SERVICES** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES *AND* NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOTIFICATION ACKNOWLEDGED Date:** _____

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Program Representative: _____ **Date:** _____

PREVIOUS FSP ENROLLMENT WITHIN 365 DAYS ☐ **YES** ☐ **NO** **AGENCY** _____

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Program Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION ON: _____ (Date) by _____ (Impact Unit Representative)

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OLDER ADULTS (AGES 60+)
FULL SERVICE PARTNERSHIP
AUTHORIZATION/NOTIFICATION FORM

CLIENT INFORMATION

***Insufficient details may delay referral process**

DMH IS/IBHIS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY:** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **OTHER**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **MEDICARE** ☐ **NONE** ☐ **PRIVATE:** _____

BENEFITS: ☐ **GR RECIPIENT** ☐ **V.A.** ☐ **SSI** ☐ **SSDI** ☐ **OTHER INCOME:**

☐ **CLIENT SERVED IN THE MILITARY** **CONSERVATOR?** ☐ **YES** ☐ **NO** **NAME:** _____

PHONE: ( ) _____

PRIMARY CONTACT: _____ **PHONE:** ( ) _____

RELATIONSHIP: _____ **PREFERRED LANGUAGE:** _____

REFERRAL SOURCE

Agency: _____ Provider # (if applicable): _____ Service Area: _____

Contact Person: _____ Phone: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ Probation ☐ APS ☐ DMH ☐ Regional Center

If Individual was referred to any other programs, please identify: _____

_____

_____

FSP Agency Representative: _____

☐ Client is aware that an FSP referral has been made on his/her behalf.

LEVEL OF SERVICE

Individual's Name: _____

DMH IS/IBHIS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ Recovery, Resilience & Reintegration Services ☐ PEI ☐ Other: _____
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

DSM-5/ICD-10 Code: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Other _____
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatric Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)

Provide Detail for Any Checked Items:

_____

_____

_____

_____

_____

Fax completed Referral/Notification Form to **Impact Unit Coordinator at (213) 738-3492**

Any questions, contact Older Adult FSP Impact team:

Elliette Montiel (213) 738-2127

Nicole Beaubien (213) 738-2327

FOCAL POPULATION

Individual's Name: _____

DMH IS/IBHIS#: _____

Check either A. or B. **Please complete to the best of your knowledge*

If the client meets the focal population for section A., the referral requires authorization.
If the client meets the focal population for section B., the referral is considered a notification.
In the event the client meets the criteria for both A. and B., the referral requires authorization.

A. ☐ AUTHORIZATION FOR ENROLLMENT
B. ☐ NOTIFICATION FOR ENROLLMENT **ENROLLMENT DATE:** _____

A. CHECK APPROPRIATE REASON(S) FOR REFERRAL:

	# Days during last 12 months
☐ Homeless ☐ [1]Chronically Homeless (HUD Standards)	_____
☐ Incarceration	_____
☐ Hospitalization	_____

☐ At imminent risk of homelessness (e.g. at risk of eviction due to code violations)

☐ Risk of going to jail (e.g. multiple interactions with law enforcement over 6 months of more)

☐ Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home

☐ Being released from SNF/ Nursing Home Facility: _____

☐ Presence of a Co-occurring disorder:

☐ Substance Abuse ☐ Developmental Disorder ☐ Medical Disorder ☐ Cognitive Disorder

☐ Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated (e.g. APS- referred clients)

☐ Serious risk of suicide (not imminent)

Provide Detail for Any Checked Items:

_____

_____

_____

_____

B. CHECK APPROPRIATE REASON(S) FOR NOTIFICATION:

☐ At risk of out of home placement (Fall risk due to chronic health conditions and numerous medications, limited or no social and/or family support, etc.)

☐ At risk of becoming involved with the criminal justice system (Prior legal/incarceration history, Little or no family or social support, inadequate or no housing, etc.)

☐ At risk of being psychiatrically hospitalized (Suicidal ideation or attempts, Failure to coordinate and take both health and psychotropic medications as prescribed, limited or no connection to non-emergency community services, etc.)

Provide additional details

_____

_____

_____

_____

[1]Chronic Homeless HUD: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has 4 episodes of homelessness in the past three years.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP APPEAL FORM

DATE: _____ ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

Reason for Appeal (Check ONE Only):

☐ DMH Impact Unit has referred an eligible client to our agency that we decline to enroll.

☐ Our agency has requested authorization to enroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to enroll.

☐ Our agency has requested authorization to disenroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to disenroll.

☐ Our agency has requested authorization to transfer a client between FSP programs and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to transfer.

Explain Reason for Appeal:

Fax completed Appeal Form and copy of denied request to appropriate **Service Area District Chief.**

↓↓TO BE COMPLETED BY SERVICE AREA DISTRICT CHIEF↓↓

District Chief Name: _____ Service Area: _____

Phone: ( ) _____ Fax: ( ) _____

DISPOSITION: ☐ APPEAL APPROVED ☐ APPEAL DENIED

Explain Reason for Decision: _____

Service Area District Chief Signature: _____ Date

Countywide District Chief Signature: _____ Date

Clear Entire Form

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT:

Name of Client/Previous Name | Birth Date | Client Number

Name of Legal Representative (If applicable)

Street Address | City, State ZIP Code

AUTHORIZES:

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Name of Agency | Name of Health Care Provider/Other

Street Address | Street Address

City, State ZIP Code | City, State ZIP Code

INFORMATION TO BE RELEASED:

☐ Assessment/Evaluation ☐ Psychological Test Results ☐ Diagnosis
☐ Laboratory Results ☐ Medication History/Current Medication ☐ Treatment
☐ Entire Record (Justify): _____
☐ Other (Specify): _____

NOTE: Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug and alcohol facilities or results of HIV test will not be disclosed unless specifically requested.

Check all that apply: ☐ Alcohol or Drug Records ☐ HIV Test Results

Method of delivery of requested records:
☐ Mail ☐ Pickup ☐ Electronic Device (CD, USB)

PURPOSE OF USE OR DISCLOSURE: (Check applicable category)

☐ Client Request
☐ Other (Specify): _____

Will the agency receive any benefits for the use or disclosure of information? ☐ Yes ☐ No

I understand that my Protected Health Information used or disclosed pursuant to this Authorization may no longer be protected by federal law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is used or disclosed, it may not be possible to recall.

EXPIRATION DATE: This Authorization is valid until _____ / _____ / _____.
Month Day Year

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive a Copy of Authorization - I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke Authorization - I understand that I have the right to revoke this Authorization at any time by notifying LACDMH in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to:

Contact Person	Agency Name
Address	City, State ZIP Code

I also understand that a revocation will not affect the ability of LACDMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization or otherwise allowed by law.

Conditions I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, LACDMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this Authorization is related to research that includes treatment, you will not receive that treatment unless this Authorization form is signed.)

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

✘	✘
Signature of Client/Legal Representative	Date

If signed by someone other than the client, state relationship and authority:

✘

REVOCATION OF AUTHORIZATION

Name of Client

Signature of Client/Legal Representative	Date

If signed by someone other than the client, print name and state relationship and authority.

Printed Name: _____

Relationship and Authority: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP DISENROLLMENT REQUEST FORM

(To be use ONLY if Client has been enrolled in FSP with FSP services rendered and claimed in the Integrated System)

DATE: _____ ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

Agency: _____ Prov. #: _____ SA: ___ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

ENROLLMENT DATE: _____ **REQUESTED DISENROLLMENT DATE:** _____

Reason for Disenrollment (Check ONE Only - Must Send Supporting Documentation):

☐ Target population criteria are not met. Briefly Explain: _____

☐ Client decided to discontinue Full Service Partnership participation after Partnership established.

☐ Client moved to another county/service area. **Aftercare Arrangements:** Briefly describe any referrals made or any linkages to ongoing care. Include date of referral, facility name, contact name and phone number:

☐ After repeated attempts to contact Client, Client cannot be located.
►Date of last face-to-face contact: _____
►Date of last check of DMH IS: _____
►Date of last check of jail/juvenile justice system: _____

Outreach Efforts: Briefly describe your attempts to locate client. Make reference to progress notes that document your efforts:

☐ Community services/program interrupted – Client's circumstances reflect a need for residential/institutional mental health services at this time (such as, IMD, MHRC, State Hospital).

☐ Community services/program interrupted – Client will be detained in juvenile hall or will be serving camp/ranch/CYA/jail/prison sentence.

☐ Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropriate. (Please include a copy of the Client Care & Coordination Plan and summary of how the goals were met.)
In addition to the statement above, please check box if statement below applies.
☐ Client no longer meets criteria for FSP. Their goals can be achieved at a lower level of service.

☐ Client deceased Date of death: _____

Impact Unit Decision

IU Signature _____ Date _____ ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Countywide Programs Decision

CW Programs Signature _____ Date _____ ☐ AUTHORIZED ☐ NOT AUTHORIZED*

NOTE: Upon Countywide's authorization to disenroll, Agency is responsible for closing the FSP episode in the integrated system, but ONLY after the final OMA assessment has been completed.

***Requires completion of Supplemental Form**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP TRANSFER REQUEST FORM

☐ Child ☐ IFCCS ☐ Wrap Child ☐ TAY ☐ Wrap TAY ☐ Adult ☐ MIST

☐ Housing ☐ Homeless ☐ Forensic ☐ AOT ☐ IMHT ☐ Older Adult

DATE: _____ **(If transfer between age groups, please check the receiving age group above as your selection)**

Agency: _____ Prov. #: _____ SA: ____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

Address: _____ Phone: _____

ENROLLMENT DATE: _____ **REQUESTED TRANSFER DATE:** _____

NEW/RECEIVING PROGRAM/AGENCY: _____ Prov. #: _____ SA: ____

New Address: _____ City: _____ Zip: _____

Contact Person: _____ Phone: _____

Reason for Transfer (Check ONE Only):

☐ Client requested a transfer.
☐ Client has moved out of Service Area.
☐ Client has moved within Service Area but closer to another FSP agency.
☐ Client's Linguistic/cultural needs.
☐ Client aged out of current services and/or client's clinical needs are better served by other age group.

AGE GROUP TRANSFERRING FROM:

☐ Child ☐ IFCCS ☐ Wrap Child ☐ TAY ☐ Wrap TAY ☐ Adult ☐ MIST

☐ Housing ☐ Homeless ☐ Forensic ☐ AOT ☐ IMHT ☐ Older Adult

☐ Other: _____

Briefly explain checked reason for transfer:

FSP Provider Acknowledgement

Current FSP Provider _____ Date _____ Receiving FSP Provider _____ Date _____

Impact Unit Decision

☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED* ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Current IU Signature _____ Date _____ Receiving IU Signature _____ Date _____

Countywide Program Decision

☐ AUTHORIZED ☐ NOT AUTHORIZED* ☐ AUTHORIZED ☐ NOT AUTHORIZED*

If Age Group Transfer:

Current CW Signature _____ Date _____ Receiving CW Signature _____ Date _____

*Requires completion of Supplemental Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP DISENROLLMENT/TRANSFER REQUEST

SUPPLEMENTAL FORM

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

↓↓TO BE COMPLETED BY IMPACT UNIT↓↓

☐ **NOT PRE-AUTHORIZED FOR DISENROLLMENT/TRANSFER**
(Explain reason for decision and indicate status of client):

Impact Unit Representative: _____ Date: _____

↓↓TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION↓↓

☐ **NOT AUTHORIZED FOR DISENROLLMENT/TRANSFER**
(Explain reason for decision and indicate status of client):

Countywide Programs Representative: _____ Date: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP REINSTATEMENT AUTHORIZATION FORM

Only to be Used Within 60 Days of Disenrollment

REFERRAL INFORMATION

This confidential information is provided to you in accord 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. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DATE: _____

LAST NAME: _____ **FIRST NAME:** _____ **DMH IS#:** _____

ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: (____) _____ **CURRENT LIVING SITUATION:** _____

Most Recent Full Service Partnership Disenrollment Date: _____

Most Recent Full Service Partnership Provider: _____

Provider Number: _____

Reason for Reinstatement: (what has happened since disenrollment that indicates why the client needs continued FSP services)

_____

_____

_____

_____

_____

_____

_____

Provider requesting reinstatement (if different from most recent provider): _____

Provider Number: _____ Phone Contact: _____

Phone Number: _____ Fax Number: _____

Conservator ? ☐ Yes ☐ No Whom ? _____

Insurance: ☐ Medi-cal ☐ Medicare ☐ V.A ☐ Private ☐ None

DISPOSITION

Individual's Name: _____

DMH IS#: _____

DATE RECEIVED: _____

To be completed by Service Area Impact Unit:

☐ Authorized for Reinstatement

☐ Not authorized for Reinstatement

Impact Unit Representative: _____ **Date:** _____

To be completed by FSP Agency:

☐ Accept Reinstatement

☐ Agency Declines to Reinstate

FSP Agency Representative: _____ **Date:** _____

To be completed by Countywide Admininstration:

☐ Authorized for Reinstatement

Countywide Programs Representative: _____ **Date:** _____

☐ Not Authorized for Reinstatement: (explain reason)

_____

_____

_____

_____

☐ Authorized Reinstatement inactive. Individual was never enrolled and no units of service billed

Countywide Programs Representative: _____ **Date:** _____