DHS/DMH/LAHSA REFERRAL FORM FOR INTERIM HOUSING PROGRAMS

****REFERRAL SUBMISSION INSTRUCTIONS - REFER TO ONE PROGRAM ONLY****

DHS INTERIM HOUSING PROGRAM

A. IF REFERRING ENTITY IS A PRIVATE OR COUNTY HOSPITAL OR DHS FUNDED COMMUNITY-BASED ORGANIZATION OR OTHER NON-DMH FUNDED PROGRAM AND THE PARTICIPANT'S PRIMARY PRESENTING ISSUE IS MEDICAL:

- Review the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs to ensure participant meets the eligibility criteria.
- Complete the DHS/DMH/LAHSA Referral Form for Interim Housing Programs **and** Supplemental Information Form for DHS Interim Housing (Attachment A).
- Complete the Authorization for the Use and Disclosure of Health and Social Service Information and the Notice of Privacy Practices Acknowledgement Forms and obtain participant signature on both forms.
- If applicable, obtain the additional supporting documentation described in the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs.
- Submit the above documents to **InterimHousing@dhs.lacounty.gov** or fax to **(213) 895-0100**.

***If referring entity is a DHS hospital/facility/outreach team/ICMS or ODR provider, use the online CHAMP application to apply for Interim Housing. Do not use the DHS/DMH/LAHSA Referral Form for Interim Housing Programs.**

DMH INTERIM HOUSING PROGRAM

B. IF REFERRING ENTITY IS A DMH DIRECTLY-OPERATED CLINIC/CONTRACT PROVIDER/OUTREACH TEAM OR OTHER NON-DHS FUNDED PROGRAM AND THE PARTICIPANT'S PRIMARY PRESENTING ISSUE IS MENTAL ILLNESS:

- Review the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs to ensure participant meets the eligibility criteria.
- Complete the DHS/DMH/LAHSA Referral Form for Interim Housing Programs.
- Complete the Authorization for Use or Disclosure of Protected Health Information form and obtain participant signature.
- Submit the above documents to **IHP@dmh.lacounty.gov**.

SELECT LAHSA BRIDGE HOUSING PROGRAMS ONLY*

C. IF REFERRING ENTITY IS A NON-DHS OR NON-DMH PROGRAM:

- Use the referral process described in Section A *if participant presents with a primary medical issue*.
- Use the referral process described in Section B *if participant presents with a primary mental health issue and is willing to accept mental health services*.
- *If participant does not present with a primary medical or mental health issue,* review the DHS/DMH/LAHSA Referral Guidelines for Interim Housing Programs to determine if they meet the eligibility criteria for any of the following LAHSA Bridge Housing programs:
  - A Bridge Home
  - Bridge Housing for Persons Exiting Institutions
  - Enhanced Bridge Housing for Women
  - Enhanced Bridge Housing for Older Adults
- Complete the DHS/DMH/LAHSA Referral Form for Interim Housing Programs if eligibility criteria is met.
- Submit the above document to **interimhousing@lahsa.org**. *(Signed authorizations are not required for LAHSA Bridge Housing.)*

***Information on how to refer to other LAHSA Interim Housing programs, including other Bridge Housing Programs, can be found at https://www.lahsa.org/documents?id=2196-lahsa-shelter-list.pdf.**

ALL REFERRING ENTITIES

D. IF PARTICIPANT PRESENTS ONLY WITH A SUBSTANCE USE ISSUE AND IS INTERESTED IN SUBSTANCE USE TREATMENT:

- Contact the Substance Abuse Service Hotline at **(844) 804-7500** to request access to substance use treatment including outpatient and residential services.

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REFERRING ENTITY INFORMATION

Date of Referral: _____ Name of Referring Entity: _____

Referring Staff Name: _____ Referring Staff Title: _____

Referring Staff Phone Number: _____ Referring Staff Email Address: _____

Alternate Contact Name: _____ Alternate Contact Title: _____

Alternate Contact Phone Number: _____ Alternate Contact Email Address: _____

Referring Entity Type:

☐ Private Hospital ☐ Private Non-DHS Urgent Care ☐ Jail/Custody Setting (Non-ODR) ☐ Skilled Nursing Facility

☐ CBEST Program ☐ Mental Health Outpatient Treatment Facility ☐ Substance Use Disorder Residential Treatment Facility

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

☐ Street-Based Outreach Program, specify: ☐ LAHSA Outreach Team ☐ DMH Outreach Team ☐ DHS Outreach Team

If Street-Based Outreach Program, select Outreach Team name.

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

☐ Other, specify: _____

☐ DHS ICMS Provider and participant is not being served by one of the above entities.

☐ Other referring entity, specify: _____

PARTICIPANT INFORMATION

Participant Name (First, Middle, Last): _____ DOB: _____ Age: _____

HMIS or comparable database # (if known): _____ CHAMP ID # (if known): _____ IBHIS # (if known): _____

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

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

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

Primary Language Spoken: _____ Limited English proficiency requiring translation services? ☐ Yes ☐ No

Participant Phone Number: _____ Participant Email Address: _____

Participant Current Location:

☐ SPA 1 - Antelope Valley ☐ SPA 2 - San Fernando Valley ☐ SPA 3 - San Gabriel Valley ☐ SPA 4 - Metro LA

☐ SPA 5 - West LA ☐ SPA 6 - South LA ☐ SPA 7 - South East LA ☐ SPA 8 - South Bay/Long Beach

Specify address or cross streets where participant typically resides:

_____

Is participant on: ☐ Probation ☐ AB 109 Probation ☐ Parole ☐ Non-Revocable Parole (Does not report to Parole Agent) ☐ N/A

Did participant exit an institution (Jail/Prison, Hospital, Foster Care, Detention Center, Residential Care Facility or Substance Use Treatment Facility) within the last 90 days? ☐ Yes ☐ No If yes, please specify discharge date: _____

Is participant conserved or does participant have a conservatorship hearing pending? ☐ Yes ☐ No

If yes, type of conservatorship: ☐ LPS ☐ Probate

Participant Name: _____ **HMIS/CHAMP/IBHIS ID#:** _____

HOUSEHOLD INFORMATION
(Only complete if participant is requesting to be housed with family)

Minor Children

Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No
Name: _____ DOB: _____ Legal Custody: ☐ Yes ☐ No

(If there are more minor children to be housed with participant, provide the above requested information in the "Additional Information" section below.)

Additional Adults in Household

Name: _____ DOB: _____ Gender: _____ Qualified Dependent*: ☐ Yes ☐ No
Name: _____ DOB: _____ Gender: _____ Qualified Dependent*: ☐ Yes ☐ No

*Qualified dependents are over age 18, incapable of employment due to mental/physical disability and dependent upon the participant for financial support.

(If there are more adult individuals to be housed with participant, provide the above requested information in the "Additional Information" section below.)

Is the participant pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Are any other members of the household pregnant? ☐ Yes ☐ No If yes, relationship to participant: _____

Additional Information: _____

_____

PRESENTING ISSUE(S)

Select all that apply to the participant.

☐ Medical, specify: _____ Primary Issue? ☐ Yes ☐ No

*If medical is the participant's primary issue, provide additional details on the DHS Supplemental Information Form (Attachment A).

☐ Mental Health, specify: _____ Primary Issue? ☐ Yes ☐ No

☐ Recent Substance Use, specify: _____ Primary Issue? ☐ Yes ☐ No

☐ Cognitive Impairments , specify: _____ Primary Issue? ☐ Yes ☐ No

☐ Other, specify: _____ Primary Issue? ☐ Yes ☐ No

☐ Participant does not have any of the above issues.

If there is an urgent issue needing immediate attention, specify: _____

_____

TUBERCULOSIS (TB) SCREENING

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

If participant has a prolonged cough (> 3 weeks) <u>AND</u> answers yes to any other TB screening question, participant must be promptly referred to a health care provider for an evaluation.

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

Participant Name: _____ **HMIS/CHAMP/IBHIS ID#:** _____

ADDITIONAL PARTICIPANT/HOUSEHOLD INFORMATION

Select all that apply to the participant.

☐ Incontinent and unable to self-care ☐ Respiratory issues (e.g., Supplemental Oxygen) ☐ Needs reminders to take medication

☐ Needs assistance with Activities of Daily Living (e.g., eating, grooming, restroom use) ☐ Significant visual impairment

☐ Significant auditory impairment

☐ Other additional information, specify: _____

Mobility Limitations (Select all that apply to any household member.)

☐ Cannot climb stairs ☐ Uses walker/cane/crutches ☐ Uses motorized wheelchair ☐ Uses manual wheelchair

☐ Cannot transfer (e.g., from wheelchair to bed) ☐ Requires a bottom bunk ☐ Other, specify: _____

Assistance Animals/Pets (Only complete if the participant/household has any animals that will accompany them into Interim Housing.)

1. Is the animal a service animal? ☐ Yes ☐ No Type: _____

2. Is the animal an emotional support animal? ☐ Yes ☐ No If yes, # of animals: _____ Type(s): _____

3. Is the animal a pet? ☐ Yes ☐ No If yes, # of animals: _____ Type(s): _____

CURRENT SLEEPING/LIVING ARRANGEMENT

Select the category that best describes the participant's current sleeping/living arrangement.

☐ Sleeping in a place not meant for human habitation, specify:

☐ Street ☐ Park ☐ Campground ☐ Vehicle ☐ Other, specify: _____

☐ Shelter/Interim Housing

☐ Hotel/Motel fully or partially subsidized by a public or non-profit agency

☐ Exiting an institution (Jail/Prison, Foster Care, Detention Center, Residential Care Facility or Substance Use Treatment Facility) where the participant has resided for:

☐ 90 days or less

☐ More than 90 days AND participant resided in Shelter/Interim Housing or a place not meant for human habitation before entering the institution

☐ Fleeing/attempting to flee domestic violence, human trafficking or sex trafficking

☐ Staying temporarily with family/friends

☐ Other sleeping/living arrangement, specify: _____

_____

INTERIM HOUSING PLACEMENT LOCATION

1. Is participant willing to reside in a communal living environment? ☐ Yes ☐ No (Most Interim Housing sites are communal living environments.)

2. Is participant willing to reside in the Skid Row area? ☐ Yes ☐ No

3. Is there any SPA(s) where the participant CANNOT live in Interim Housing? Select all that apply.

☐ SPA 1 - Antelope Valley ☐ SPA 2 - San Fernando Valley ☐ SPA 3 - San Gabriel Valley ☐ SPA 4 - Metro LA

☐ SPA 5 - West LA ☐ SPA 6 - South LA ☐ SPA 7 - South East LA ☐ SPA 8 - South Bay

4. Does participant have an Interim Housing provider preference? ☐ Yes ☐ No If yes, please specify: _____

5. Is participant willing to go to an alternate provider? ☐ Yes ☐ No