**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH (DMH)**

# ENRICHED RESIDENTIAL CARE PROGRAM (ERCP) REFERRAL

## REFERRING AGENCY/STAFF INFORMATION

Referral Date: _____ Program Type: ☐ FSP ☐ HOME ☐ ICD ☐ RRR ☐ PG

Referring Agency: _____ Referring Staff Name: _____

Referring Staff Phone Number: _____ Referring Staff Email: _____

## CLIENT INFORMATION

Client IBHIS #: _____ Client DOB _____

Client Last Name: _____ Client First Name: _____

Client Gender: ☐ M ☐ F ☐ Trans Man ☐ Trans Woman ☐ Other Gender Identity, specify: _____

Where is client currently residing? _____ Is this a licensed residential facility? ☐ No ☐ Yes

Does client have mobility needs? ☐ No ☐ Yes, specify: _____

Does client have income? ☐ No ☐ Yes, source: _____ Monthly Amount: $ _____

Does client have SSI application or appeal in progress? ☐ No ☐ Yes, date: _____

***(NOTE: Clients receiving GR/CalFresh will be required to terminate these benefits if approved for ERCP and, if eligible, apply for SSI.)***

Has client been approved for admission by a **Licensed** Residential Facility? ☐ No ☐ Yes

- If yes, specify: Facility Name: _____

Facility Address: _____

Facility Contact: _____

Facility Contact Phone Number: _____ Facility Contact Email: _____

What agency will provide client with ongoing, **field-based services** once admitted to a Licensed Residential Facility?

☐ Referring Agency

☐ Other Agency, specify: Agency Name: _____

Agency Contact: _____

Agency Contact Phone Number: _____ Agency Contact Email: _____

Is this agency an FSP provider? ☐ No ☐ Yes, Directly-Operated FSP ☐ Yes, Contract FSP

***(NOTE: Clients served by a contract FSP provider are eligible for Enhanced Services Rate payments only. It is expected that contract FSP providers use Client Supportive Services (CSS) funds to pay for client rent payments and Personal & Incidental expenses.)***

******Securely email completed referral and PHI Authorization to DMH_ERC@dmh.lacounty.gov ******

## REFERRAL DISPOSITION
***(TO BE COMPLETED BY DMH CHEERD STAFF ONLY)***

Is client approved for ERCP? ☐ No, specify reason: _____

☐ Yes, client is approved for: ☐ Rent Payment ☐ Personal & Incidental (P&I) Funds

☐ Enhanced Services Rate
($25 per day unless otherwise negotiated)

CHEERD Staff Signature: _____ Date: _____

CHEERD Staff Name: _____ Expiration Date: _____