COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP DISENROLLMENT REQUEST FORM

(To be used ONLY if Client has been enrolled in FSP with FSP services rendered and claimed in IBHIS)

DATE: _____ ☐ **Child/Young Adult (age 0-20)** ☐ **Adult (age 21+)**

Agency: _____ Prov. #: _____ SA: ___ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **IBHIS#:** _____

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 IBHIS: _____
- ► 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 the 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: _____

Navigation Team Decision

NT Signature _____ _____ ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Date

NOTE: Upon Countywide's authorization to disenroll, Agency is responsible for closing the FSP episode in the IBHIS system, but ONLY after the final OMA assessment has been completed.

***Requires completion of Supplemental Form**