Prevent Homelessness Promote Health (PH^2) – DHS/DMH Collaboration
Physical/Mental Health Assistance Referral

REFERRING AGENCY CONTACT INFORMATION

Agency: | Date:

Staff Name: | Email: | Phone:

Supervisor Name: | Email: | Phone:

CLIENT INFORMATION

Reason for referral: ☐ Physical Health (Submit referral to: hfhmedicalcasemanagement@dhs.lacounty.gov)
☐ Mental Health (Submit referral to: phsquared@dmh.lacounty.gov)

Client Name: | D.O.B.: | SSN: | Gender:

Ethnicity: | Primary Language: | Orchid ID: | Champ ID:

Type of housing: ☐ Board and Care ☐ Market Rate ☐ Project Based ☐ Scattered Site
Length of housing:

Client Address: | Client Phone: | Service Area:

Other client information:

PHYSICAL HEALTH INFORMATION

Client Health Insurance: | ID#: | Expiration Date:

Client PCP: | Location: | Clinic Phone #: | Care Manager Ph. #:

Other Provider: | Location: | Clinic Phone #: | Specialty:

How many times has the client accessed the ER or inpatient care in the last 12 months (if known)?

Date: | Facility: | Date: | Facility:

Date: | Facility: | Date: | Facility:

Date: | Facility: | Date: | Facility:

Is the client making regular visits to a primary care physician? ☐ Yes ☐ No

If ***NO***, why is the client not accessing primary care services?

Is the client currently prescribed any medications? ☐ Yes ☐ No

List all medications:

Is the client compliant with the prescribed medication plan? ☐ Yes ☐ No

If ***NO***, is the client's health worse due to poor medication adherence? ☐ Yes ☐ No

Recent incarceration/transition out of jail? ☐ Yes ☐ No

MENTAL HEALTH INFORMATION

Is the client currently receiving mental health services? ☐ Yes ☐ No If Yes, IBHIS #:

Type of housing voucher: ☐ Age 16-25 ☐ 65 years or older ☐ Family Unit ☐ Single Adult ☐Veteran

☐ Other:

Check all concerns/tenant violations and list dates:

☐ Aggressive/Violent Behavior ☐ Destruction of Property ☐ Failure to Pay ☐ Fire Safety/Health Hazard

☐ Hoarding ☐ Infestation ☐ Legal ☐ Relationship Conflicts ☐ Substance Abuse

☐ Other:

Is client at-risk of returning to homelessness? ☐ Yes ☐ No

Is eviction expected w/in the next 30 days? ☐ Yes ☐ No

Have there been or are there currently any safety issues? ☐ Yes ☐ No If ***YES***, describe below:

SERVICES NEEDED

☐ Assessment of higher level of care/In-Home Caregiving (IHCG)/In-Home Supportive Services (IHSS)

☐ Medication review/adherence support (short-term)

☐ Substance Use Disorder (SUD) assessment and short-term support/linkage

☐ Functional assessment and short-term support/linkage

☐ Other (please see attached sheet for details)

☐ Physical health assessment and short-term support/linkage

☐ Mental health assessment and short-term support/linkage

☐ Assistance with housing accommodations

NOTE: Permanent Supportive Housing (PSH) RNs cannot do blood draws or 5150 holds.
Intensive Case Management Services (ICMS) is responsible for doing routine accompaniments and transitions of care as well as ensuring that clients have active health insurance and are empaneled to primary care. ICMS is also responsible for housing and social services support (food, transportation, etc.), M-F only.

ADDITIONAL INFORMATION RELEVANT TO THIS REQUEST

Medical/mental health diagnosis if known:

**If eligible for assistance, HFH Nursing staff OR DMH will contact agency staff. HFH OR DMH Program Manager will inform agency staff if the participant is NOT eligible for assistance.

Submit **mental health** referral to: phsquared@dmh.lacounty.gov
AND **physical health** referral to: hfhmedicalcasemanagement@dhs.lacounty.gov.