LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

Full Service Partnership (FSP) Key Event Change (KEC)

Adult: Ages 26-59

ADMINISTRATIVE INFORMATION

DMH# _____ Assessment Date _____

Client First Name _____ Provider Number _____ (4 characters)

Client Last Name _____

Client DOB _____

CHANGE IN ADMINISTRATIVE INFORMATION

(skip this section if there are no changes)

New Provider Number: _____ (4 characters)

Date of Provider Number Change: _____

New Partnership Service Coordinator (Last Name): _____

Date of Partnership Service Coordinator Change: _____

Date of Program Name Change: _____

New Program Name (select one)

Programs with an asterisk have ended as of 6/30/21

- ◯ Adult FSP
- ◯ Transitional Age Youth (TAY) FSP*
- ◯ Older Adult FSP*
- ◯ Assisted Outpatient Treatment FSP (AOT-LA-FSP)
- ◯ Integrated Mobile Health Team FSP (IMHT-FSP)
- ◯ Forensic FSP (F-FSP)*
- ◯ Homeless FSP
- ◯ Housing FSP-MHSA*
- ◯ Housing FSP-Measure H*

PROGRAM INFORMATION

In which additional program(s) is the client CURRENTLY involved? (check all that apply)

AB2034 PROGRAM

◯ Now enrolled in AB2034 Program

◯ No longer participating in the AB2034 Program

Date of AB2034 Program Change: _____

GOVERNER'S HOMELESS INITIATIVE (GHI) PROGRAM

◯ Now enrolled in GHI Program

◯ No longer participating in the GHI Program

Date of Governor's Homeless Initiative (GHI) Program Change: _____

MHSA HOUSING PROGRAM

◯ Now enrolled in MHSA Housing Program

◯ No longer participating in the MHSA Housing Program

Date of MHSA Housing Program Change: _____

Name _____ DMH# _____

Agency _____ Provider# _____

Los Angeles County – Department of Mental Health

CHANGE IN ADMINISTRATIVE INFORMATION *continued*

(skip this section if there are no changes)

Indicate NEW Partnership Status Date of Partnership Status Change: _____

☐ Discontinuation/Interruption of Full Service Partnership and/or Community Services/Program (**indicate the reason below**).
☐ Reestablishment of Full Service Partnership and/or Community Services/Program.

If there is a DISCONTINUATION/INTERRUPTION of Full Service Partnership and/or Community Services/Program, indicate the reason (select one)

☐ Target Criteria: Target population criteria are not met.
☐ Client Discontinued: Client decided to discontinue Full Service Partnership participation after partnership established.
☐ Moved: Client moved to another County/service area.
☐ Not Located: After repeated attempts to contact client, s/he cannot be located.
☐ Residential/Institutional Mental Health Services: Client's circumstances reflect a need for Residential/Institutional Mental Health Services at this time (such as State Hospital).
☐ Jail: Community Services/Program interrupted.
☐ Prison: Community Services/Program interrupted.
☐ Met Goals: Client has successfully met their goals such that discontinuation of Full Service Partnership is appropriate.
☐ Deceased: Client is deceased.

Name _____ DMH# _____

Agency _____ Provider# _____

Los Angeles County – Department of Mental Health

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

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ADMINISTRATIVE INFORMATION			
DMH#		Assessment Date	
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Client DOB			

LIVING ARRANGEMENTS

(skip this section if there are no changes)

Date of Residential Status Change: _____

Indicate NEW residential status (select one)	RESIDENTIAL TYPE
GENERAL LIVING ARRANGEMENT	
☐	With adult family member(s) other than parents
☐	In an apartment or house alone/with spouse/partner/minor children/other dependents/roommate (must hold lease or share in rent/mortgage)
☐	With one or both biological/adoptive parents
☐	Single Room Occupancy (SRO) (must hold lease)
SHELTER/HOMELESS	
☐	Emergency Shelter
☐	Homeless (includes people living in their cars)
☐	Temporary Housing (includes people living with friends but paying no rent)
HOSPITAL	
☐	Acute Medical Hospital
☐	Acute Psychiatric Hospital/Psychiatric Health Facility (PHF)
☐	State Psychiatric Hospital
RESIDENTIAL PROGRAM	
☐	Alcohol or Substance Abuse Residential Rehabilitation Center
☐	Crisis Residential Housing
☐	Institution for Mental Disease (IMD)
☐	Long-Term Residential Program
☐	Mental Health Rehabilitation Center (MHRC)
☐	Skilled Nursing Facility (physical)
☐	Skilled Nursing Facility (psychiatric)
☐	Transitional Residential Program

Name _____ DMH# _____

Agency _____ Provider# _____

Los Angeles County – Department of Mental Health

LIVING ARRANGEMENTS *continued* *(skip this section if there are no changes)*	
Indicate NEW residential status (select one)	**RESIDENTIAL TYPE**
JUSTICE PLACEMENT	
☐	Jail
☐	Prison
SUPERVISED PLACEMENT	
☐	Assisted Living Facility
☐	Group Living Home
☐	Licensed Community Care Facility (Board and Care)
☐	Sober Living Home
☐	Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants, etc.)
OTHER	
☐	Other
☐	Unknown

Name _____ DMH# _____

Agency _____ Provider# _____

Los Angeles County – Department of Mental Health

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

Full Service Partnership (FSP) Key Event Change (KEC)

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ADMINISTRATIVE INFORMATION

DMH# _____ Assessment Date _____

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DAILY ACTIVITIES/VOCATIONAL/EDUCATIONAL LEVEL

(skip this section if there are no changes)

GRADE LEVEL INFORMATION

Date of Grade Level Completion: _____

Highest Level of Education Attained (**select one**)

- ◯ No High School Diploma/No GED
- ◯ GED Coursework
- ◯ High School Diploma/GED
- ◯ Some College/Some Technical or Vocational Training
- ◯ Associate's Degree (e.g. A.A., A.S.)/Technical or Vocational Degree
- ◯ Bachelor's Degree (e.g., B.A., B.S.)
- ◯ Master's Degree (e.g., M.A., M.S.)
- ◯ Doctoral Degree (e.g., M.D., Ph.D.)

EDUCATIONAL SETTING

Date of Educational Setting Change: _____

If there are any educational setting changes, indicate ALL NEW and ONGOING statuses including those previously reported (**check all that apply**)

- ☐ Not in school of any kind
- ☐ High School/Adult Education
- ☐ Technical/Vocational School
- ☐ Community College/4-year College
- ☐ Graduate School
- ☐ Other

If the client is stopping school, did the client complete a class and/or program? ◯ Yes ◯ No

Does one of the client's CURRENT recovery goals include any kind of education AT THIS TIME? ◯ Yes ◯ No

Name _____ DMH# _____

Agency _____ Provider# _____

Los Angeles County – Department of Mental Health

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

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DAILY ACTIVITIES/VOCATIONAL/EDUCATIONAL LEVEL *continued*

(skip this section if there are no changes)

Date of Employment Change: _____

CURRENT EMPLOYMENT If there are any changes to the client's employment, indicate ALL NEW and ONGOING statuses, including those previously reported.	Average Number of Hours per Week	Average Hourly Wage
☐ **Unemployed: Check if the client is Unemployed at this time.**		
Competitive Employment Paid employment in the community in a position that is also open to individuals without a disability.		
Supported Employment Competitive Employment (see above) with ongoing on-site or off-site job-related support services provided.		
Transitional Employment/Enclave Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.		
Paid In-House Work (Sheltered Workshop/Work Experience/Agency-Owned Business) Paid jobs open only to program participants with a disability. • *A Sheltered Workshop* usually offers sub-minimum wage work in a simulated environment. • *A Work Experience (Adjustment) Program* within an agency provides exposure to the standard expectations and advantages of employment. • *An Agency-Owned Business* serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.		
Non-paid (Volunteer) Work Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.		
Other Gainful/Employment Activity Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).		

Does one of the client's CURRENT recovery goals include any kind of employment AT THIS TIME? ◯ Yes ◯ No

Name _____ DMH# _____

Agency _____ Provider# _____

Los Angeles County – Department of Mental Health

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

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EMERGENCY INTERVENTION

(skip this section if there are no changes)

EMERGENCY ROOM/CRISIS STABILIZATION

Date of Emergency Intervention: _____

Indicate the type of Emergency Intervention (**select one**)

- ◯ ER - Physical Health
- ◯ ER - Psychiatric
- ◯ ER - Substance Abuse
- ◯ Crisis Stabilization/Urgent Care Center (UCC) - Psychiatric
- ◯ Crisis Stabilization/Urgent Care Center (UCC) - Substance Abuse

PSYCHIATRIC MOBILE RESPONSE TEAM OR 24/7 CRISIS RESPONSE TEAM

Date of Psychiatric Mobile Response Team or 24/7 Crisis Response Team Intervention: _____

Did the Psychiatric Mobile Response Team or 24/7 Crisis Response Team call result in a hospitalization? ◯ Yes ◯ No

Name _____ DMH# _____

Agency _____ Provider# _____

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LEGAL

(skip this section if there are no changes)

ARREST INFORMATION

Date of client's arrest: _____

PROBATION INFORMATION

Date client broke the terms of probation: _____

Date of probation status change: _____

Indicate new probation status (**select one**)

◯ Removed from probation

◯ Placed on probation

CONSERVATORSHIP INFORMATION

Date of conservatorship status change: _____

Indicate new conservatorship status (**select one**)

◯ Removed from conservatorship

◯ Placed on conservatorship

PAYEE INFORMATION

Date of payee status change: _____

Indicate new payee status (**select one**)

◯ Removed from payee status

◯ Placed on payee status

Name _____ DMH# _____

Agency _____ Provider# _____

Los Angeles County – Department of Mental Health