

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH (DMH)  
ENRICHED RESIDENTIAL CARE (ERC) PROGRAM REFERRAL FORM**

**REFERRING AGENCY/STAFF INFORMATION**

Referral Date: \_\_\_\_\_ Program Type:  FSP  HOME  Hollywood 2.0  Public Guardian  
 ICD  IHOP  CARE Court  Other: \_\_\_\_\_  
 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, describe: \_\_\_\_\_  
 Is the client a veteran?  Yes  No  
 Is the client conserved?  Yes  No  
 Client's current living situation? \_\_\_\_\_ Is this a licensed residential care facility?  No  Yes  
 Has client been homeless in the past 12 months?  No  Yes Is client exiting a higher level of care?  No  Yes  
(i.e., IMD, ERS, hospital)  
 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 If yes, date of SSI application \_\_\_\_\_

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

Has client been approved for admission by a **Licensed** Residential Care 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 Care 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 If yes, type of FSP:  Directly-Operated FSP  Contracted FSP  
 If contracted FSP, does agency agree to pay SSI rate and P&I using Client Supportive Services (CSS) funding?  No  Yes

**\*\*\*Securely email completed forms to [DMH\\_ERC@dmh.lacounty.gov](mailto:DMH_ERC@dmh.lacounty.gov)\*\*\***

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

Is client approved for ERC?  No, specify reason: \_\_\_\_\_  
 Yes, client is approved for:  Rent Payment  P&I Funds  
 Enhanced Services Rate  Community Care Expansion  
 ERC Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 ERC Staff Name: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institution Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to whom it pertains unless otherwise permitted by law.