LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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

REFERRING AGENCY/STAFF INFORMATION

☐ FSP ☐ HOME ☐ Hollywood 2.0 ☐ Public Guardian

Referral Date: _____ Program Type: ☐ 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 the current living situation a licensed residential care facility? ☐ No ☐ Yes ☐ Unsure

Has client been homeless in the past 12 months? ☐ No ☐ Yes

Is client exiting a higher level of care? (i.e., IMD, ERS, hospital) ☐ No ☐ Yes

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

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

Has an SSI/SSP/CAPI application been submitted? ☐ Yes: Application Date: _____

☐ No, please explain: _____

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

Is there an identified **Licensed** Residential Care Facility? ☐ Yes ☐ No

Facility Identification Status: ☐ Facility Has Approved Admission ☐ Pending Interview/Tour ☐ Currently Searching

If approved, specify: Facility Name: _____

Facility Address: _____

Facility Contact: _____

Facility Contact Phone Number: Facility Contact Email:

What agency will provide the 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 ******

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: _____