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

A. Submitter Information

Facility Name:			Date Submitted:
Staff Name:		Staff Email:	Phone Number:

B. Client Exit/Relocation Information

IBHIS #:		First Name:		Last Name:	
Exit Type:	☐ Permanent ☐ Relocation ☐ Temporary/Bed Hold			Is the client expected to return?	☐ No ☐ Yes
Admission Date:		Exit Date:		Expected Return Date:	

C. Exit/Relocation Reason (Select Only One)

Transition to Other Permanent Housing Type:	☐ Family/Friend Unification ☐ Obtained Other Housing Opportunity ☐ Obtained Permanent Supportive Housing	
Reasons Related to Behaviors:	☐ Criminal Activity/Violence ☐ Disagreement with Rules/Persons ☐ Eviction ☐ Incarcerated ☐ Left Against Medical Advice	☐ Non-Payment of Rent ☐ Required Higher Level of Care ☐ Substance Use Related ☐ Voluntary Departure – With Notice ☐ Voluntary Departure – Without Notice
Other Circumstances:	☐ Assisted Living Waiver Program ☐ CalAIM Community Supports ☐ Deceased	☐ Facility Closure ☐ Participant Geographic Request

D. Exit/Relocation Destination (Select Only One)

Homeless Situations:	☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter ☐ Safe Haven
Institutional Situations:	☐ Foster care home or group home ☐ Psychiatric hospital or facility ☐ Substance abuse treatment facility or detox center	☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison, or juvenile detention facility ☐ Long-term care facility or nursing home - If Long-Term Care or Nursing Home is selected, is the facility a licensed board and care (ARF, RCFE)? ☐ No ☐ Yes
Temporary Housing Situations:	☐ Transitional housing for homeless persons (including homeless youth) ☐ Residential project or halfway house with no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher	☐ Host Home (non-crisis) ☐ Staying or living in a friend's room, apartment, or house ☐ Staying or living in a family member's room, apartment, or house
Permanent Housing Situations:	☐ Owned by client:	☐ **With** ongoing housing subsidy **OR** ☐ **Without** ongoing housing subsidy
	☐ Rental by client:	☐ **With** ongoing housing subsidy **OR** ☐ **Without** ongoing housing subsidy
Rental Subsidy Type:	☐ VASH ☐ Client Rental with Other Subsidy ☐ Permanent Supportive Housing ☐ Other permanent housing for formerly homeless persons ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected ☐ Other:	

E. New Housing Information (if known)

Facility Name:		Address:			
Contact Name:		Contact Email:		Phone Number:	
Monthly Rent (All Rental Subsidies):	$ 0.00	Shared Housing?	☐ No ☐ Yes	Shared Room?	☐ No ☐ Yes

F. Disabling Conditions and Barriers at Exit	
Check all conditions or barriers that apply to the client:	
Physical Disability:	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected ☐ Condition is long-term and substantially impairs independent living
Learning or Developmental Disability:	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected
Chronic Health Condition:	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected ☐ Condition is long-term and substantially impairs independent living
Diagnosed with AIDS or HIV Positive:	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected
Mental Health Disorder:	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected ☐ Condition is long-term and substantially impairs independent living
Current Drug and/or Alcohol Problem:	☐ No ☐ Drug ☐ Alcohol ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected ☐ Condition is long-term and substantially impairs independent living

G. Domestic Violence and Other History at Exit	
Is client a survivor of domestic violence?	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected
If the client answers "Yes", the questions below are required:	
How long ago did the client have this experience?	# of: ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Prefers Not to Answer ☐ Unknown ☐ Data Not Collected
Is the client currently fleeing?	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected

H. Employment at Exit	
Is the client currently employed?	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected
If "No", is the client…	☐ Looking for work ☐ Not looking for work ☐ Unable to work
If "Yes", what type of employment?	☐ Full-Time ☐ Part-Time ☐ Seasonal/Sporadic (including day labor)

I. Cash Income for Individuals at Exit				
Does the client receive any cash income?	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected			
If "Yes":	☐ Earned Income (wages/cash):	$ 0.00	☐ Temp. Assistance for Needy Families (CalWORKs):	$ 0.00
(Specify)	☐ Unemployment Insurance:	$ 0.00	☐ General Assistance (GA)/General Relief (GR):	$ 0.00
	☐ Alimony and Other Spousal:	$ 0.00	☐ Social Security Disability Insurance (SSDI):	$ 0.00
	☐ Retirement from Social Security:	$ 0.00	☐ Pension or Retirement Income from a Former Job:	$ 0.00
	☐ Child Support:	$ 0.00	☐ VA Service-Connected Disability Compensation:	$ 0.00
	☐ Private Disability Insurance:	$ 0.00	☐ VA Service-Connected Disability Pension:	$ 0.00
	☐ Worker's Compensation:	$ 0.00	☐ Cash Assistance Program for Immigrants (CAPI):	$ 0.00
	☐ Supplemental Security Income:	$ 0.00	☐ Other Source:	$ 0.00
SSI/SSP/CAPI Application Date:			**Total Monthly Cash Income for Individual:**	$ 0.00
If an SSI/SSP/CAPI application has not been submitted, please explain:				
Cash Income Documentation:	☐ GR Form ☐ CalWORKs Form ☐ Pension Letter/Stub ☐ Pay Stub ☐ SSDI Form ☐ SSI Form ☐ Unemployment Insurance Forms ☐ Unemployment Forms ☐ Self-Employment Docs. ☐ Child Support Forms ☐ Employer Printout/Letter ☐ Social Security Forms ☐ VA Docs. ☐ W-2 Forms ☐ Utility Allowance ☐ Workman's Comp. ☐ Self-Declaration ☐ Other Docs, Specify:			

J. Non-Cash Benefits at Exit	
Does the client have any non-cash income?	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected
What non-cash benefits does the client receive?	☐ Food Stamps/CalFresh (Supplemental Nutrition Assistance Program SNAP) ☐ WIC (Supplemental Nutrition Program for Women, Infants, Children) ☐ CalWORKs Child Care Services ☐ CalWORKs Transportation Services ☐ Other CalWORKs-Funded Services ☐ Other Source:

K. Health Insurance at Exit	
Is client covered by any health insurance?	☐ No ☐ Yes ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected
If "No", Reason:	☐ Applied; Pending ☐ Applied; Not Eligible ☐ Did Not Apply ☐ N/A ☐ Prefers Not to Answer ☐ Unknown ☐ Not Collected
If "Yes", Health Insurance:	☐ Medi-Cal (Medicaid) ☐ Medicare ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ State Children's Health Insurance Program (SCHIP) ☐ VA Medical Services ☐ Employer-Provided Insurance ☐ COBRA ☐ Other:
Health Insurance Provider:	☐ L.A. Care ☐ Molina ☐ My Health LA (DHS) ☐ Anthem Blue Cross ☐ Health Net ☐ Care 1st Health Plan ☐ SCAN Health Plan ☐ VA ☐ Kaiser Permanente ☐ Unknown ☐ Other:

***Once client exits facility, securely email completed form within 3 days to DMH_ERC@dmh.lacounty.gov ***

---------- Section below to be completed by DMH ERC Staff Only ----------

Exit/Relocation Disposition			
Date DMH ERC Notified:		Approved by ERC Staff:	
☐ Email ☐ Phone Call ☐ Forfeit 30-Day Notice of Payment	ERC Staff Signature:		Date:
	Forfeiture Reason:	☐ Death ☐ Sister Facility ☐ >72 Hours ☐ Eviction ☐ CalAIM/Assisted Living Waiver	