



Los Angeles County Department of Mental Health Child and Youth Full-Service Partnership Referral Form

Child & Youth FSP is an intensive mental health program that is child-focused, family-centered, strengths based and needs driven planning process to provide individualized, comprehensive services. Using a collaborative team approach, Child & Youth FSP supports children and youth with significant mental health and behavioral needs while helping families build on their strengths and connect with community resources to meet their goals

Referral Date			
Date:			
Referral Type		Age Group	
☐ Child Welfare		☐ 0-5	
☐ Community		☐ 6-15	
☐ Probation		☐ 16-25	
Client Information			
IBHIS:	Client is aware of FSP referral being made on their behalf: ☐ YES ☐ NO		
Client Name:		DOB:	Age:
Phone:		Preferred Language:	
Address:		City:	Zip code:
Insurance	☐ Medi-Cal#: ☐ Private Insurance		
	Managed Care Plan: ☐ None		
Conservator Information			
Conservator ☐ YES ☐ NO		☐ Public	☐ Private Relationship:
Name:		Phone:	
Current Living situation			
☐ Supervised Independent Living Placement (SILP) ☐ Home of Parent ☐ Relative ☐ Resource Home		☐ Intensive Services Foster Care (ISFC) ☐ Short Term Residential Therapeutic Program (STRTP) Facility Name: _____	



Parent/Guardian/Caregiver information		
Name:	Phone:	Preferred Language
Referring Provider Information		
Provider Name & Provider #:	Referring Practitioner/Title:	
Phone:	Email:	
Is Individual Currently Receiving MHS from your agency ☐ YES ☐ NO		
Other Agency Involvement:		
☐ DCFS		
DCFS office:		
CSW Name:	Phone:	Email:
SCSW Name:	Phone:	Email:
☐ Probation		
PDJ #:		
Probation officer Name:	Phone:	Email:
SDPO Name:	Phone:	Email:
☐ Parole		
☐ Regional Center		
☐ Other		
If individual referred by another program, please identify:		
FSP Eligibility Criteria (check all that apply)		
☐ Experienced psychiatric hospitalization within the last 3 months (if checked specify) _____	☐ One or more placement changes in the past 6 months	
☐ At risk of hospitalization or crisis/emergency care	☐ Risk of Commercial Sexual Exploitation of Children (CSEC)	
	☐ Involved in child welfare or former foster youth	



Specify # of visits within the past 90 days for the following: Psychiatric urgent care center: _____ Emergency room for psychiatric disorder: _____ Encounters with emergency outreach team: _____ ☐ Currently unhoused ☐ At risk of homelessness Specify current living situation and indicators of risk: _____ ☐ Suicidal/Homicidal Ideation and or attempts ☐ Self-harm behavior ☐ Co-occurring substance use disorder	☐ At risk for previous involvement with Probation Dept ☐ History of aggressive behavior ☐ At risk of running away or currently considered runaway ☐ Transitioning into community from restrictive setting ☐ School Suspensions and/or expulsions, within the last school year ☐ School Absences considered chronically truant (missing 10% of school days within a year) ☐ Experiencing prodromal or first episode of psychosis ☐ Youth in the care of a parent or caregiver with mental health or co-occurring substance use disorder ☐ Has challenges with age-appropriate daily living skills
Diagnosis	
DSM-5/ICD-10 (if known): _____ Co-Occurring Substance Use Disorder: _____ CANS LOC score if known, within the last 6 months: _____ LOCUS (ages 21+) Level of Care score, if known within the last 6 months _____	
Provide details for any checked items, describe client's immediate risk, safety concerns, and most concerning behavior, including danger to self and others:	
Describe how clients' mental health symptoms impact their daily functioning, including any school or home disruptions	



Document any pertinent additional information regarding the client (i.e. client is difficult to engage, client prefers female staff, language barriers, mental health hx etc.)

Additional Referral info (i.e. special accommodation/accessibility needs, etc.)

All DMH entities (directly operated and contracted) must submit the referral form via the Service Request Tracking System (SRTS).

For non-DMH entities, please fax the completed referral form to the navigation team for your Service Area (SA)

SA 1 (Antelope Valley): 661 449-3704

SA 5 (West LA): 310 496-3266

SA 2 (San Fernando and Santa Clarita Valley): 213 652-1815

SA 6 (South LA) 323 978-6155

SA 3 (San Gabriel Valley): 626 608-9086

SA 7 (East LA) 213 402-2309

SA 4 (Metro LA): 213 947-4030

SA 8 (Long Beach/South Bay) 562 684-4512

Referrals for children involved in Child Welfare and/or Probation shall be submitted to the designated SA inbox.

SA 1 SA1Wraparound@dmh.lacounty.gov

SA5 SA5Wraparound@dmh.lacounty.gov

SA 2 SA2@Wraparound@dmh.lacounty.gov

SA6 SA6Wraparound@dmh.lacounty.gov

SA3 SA3@Wraparound@dmh.lacounty.gov

SA7 SA7Wraparound@dmh.lacounty.gov

SA4 SA4Wraparound@dmh.lacounty.gov

SA8 SA8Wraparound@dmh.lacounty.gov

Navigator information : 1211466_Navigators_ContactInformation-updated12.15.2025.pdf

For general questions, please contact Wraparound@dmh.lacounty.gov