



Los Angeles County Department of Mental Health

ADULTS (Ages 18+)

Full-Service Partnership Intensive Case Management (FSP-ICM)

Referral Form

FSP-ICM provides a comprehensive array of community-based services for individuals at risk due to serious behavioral health conditions. Services are delivered through a coordinated, team-based, whole-person approach. The program is designed to support clients with improving functional abilities and employment outcomes, reducing homelessness and involvement with the criminal justice system, and minimizing use of urgent medical and psychiatric care, emergency room visits, and hospitalizations.

Referral Date									
Date:									
Client Information									
IBHIS:		Client is aware FSP referral has been made on their behalf: ☐ YES ☐ NO							
Client Name:						DOB:		Age:	
Phone:					Preferred Language:				
Address:				City:			Zip code:		
☐ Current living situation:									
Insurance	☐ Medi-Cal # :			☐ Medicare #:			☐ Private		☐ None
Benefits	☐ GR	☐ VA	☐ SSI	☐ SSDI	Other income:				
☐ Client served in the military									
Conservator Information									
Conservator		☐ YES ☐ NO		☐ Public Guardian		☐ Private		Relationship:	
Conservator Name:						Phone:			
Referring Provider Information									
Provider Name:						Provider #:			
Referring Practitioner/ Title:					Phone:		Email:		
Is individual currently receiving MH Services from your agency: ☐ YES ☐ NO									



Other Agency Involvement

- ☐ General Relief (GR) / Department of Public Social Services (DPSS)
- ☐ Regional Center (RC)
- ☐ Adult Protective Services (APS)
- ☐ Office of Diversion and Reentry (ODR)
- ☐ Post Release Community Supervision (PRCS) California Department of Corrections and Rehabilitation

(CDCR) #: _____

- ☐ Individual is subject to registration requirements (e.g. sex offender, arson)

Specify: _____

- ☐ Probation

- ☐ Parole

Probation/Parole Officer's Name: _____

Phone: _____

Email: _____

If individual was referred to another program, please identify:

FSP-ICM Eligibility Criteria (*check all that applies*)

- ☐ Recent Hospitalization (If checked provide dates):

- ☐ At risk of Hospitalization or crisis or Emergency care (if checked, provide the following for the past 90 days)

of visits to psychiatric Urgent Care: _____

of ER room visits for psychiatric disorders: _____

of encounters with emergency outreach team: _____

- ☐ Currently Unhoused
- ☐ At risk of homelessness

Specify current living situation/indicators of risk:

- ☐ Has persistent, recurrent or severe major symptoms of mental illness

- ☐ Has Co-occurring substance use disorder

- ☐ High risk or recent history of involvement with criminal justice system (if checked specify):

Recent arrests/Release dates:

of contacts with law enforcement within the past 12 months: _____

- ☐ Has an inability to participate in office-based services



Provide details for any checked items below

Diagnostic Consideration

DSM-5/ICM-10 Code:

Co-Occurring Substance Use Disorder:

Level of Care Utilization Scale (LOCUS) Score within the past 6 months (if known):

Check all that apply

☐ Aggressive Ideation

☐ Aggressive Threats (history or current)

☐ Inappropriate Sexual Ideation

☐ Symptoms of psychosis

☐ Aggressive Acts

☐ Aggressive Acts (history of current)

☐ Fire Setting Ideation or Acts

☐ Inappropriate Sexual Acts

☐ Suicide ideation/Attempts

☐ Tarasoff of Notification (history or current)

Other: _____

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 their ability to care for themselves, work or manage homemaker roles, access essential services, or maintain a safe living situation:

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 or

SA1FSPFax@dmh.lacounty.gov

SA 2 (San Fernando and Santa Clarita Valley):

213-652-1815

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

SA 4 (Metro LA): 213-947-4030 or

SA4NavigationFax@dmh.lacounty.gov

SA 5 (West LA): 310-496-3266

SA 6 (South LA): 213-867-5555 or

SA6AdultFSPFax@dmh.lacounty.gov

SA 7 (East LA): 213-402-2309 or

Sa7adminfax@dmh.lacounty.gov

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

Navigator Contact Information: [1211466 Navigators ContactInformation-updated12.15.2025.pdf](#)