COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OLDER ADULT (AGES 60+) FULL SERVICE PARTNERSHIP REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

*Insufficient details may delay referral process

DMH IS#: _____

DATE: _____ SSN: _____

LAST NAME: _____ FIRST NAME: _____ PREFERRED LANGUAGE: _____

DOB: _____ AGE: _____ RACE/ ETHNICITY _____ GENDER: ☐ M ☐ F ☐ UNKNOWN

CONTACT ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE ( ) _____ CURRENT LIVING SITUATION: _____

INSURANCE: ☐ MEDI-CAL ☐ MEDICARE ☐ PRIVATE ☐ HWLA ☐ NONE

BENEFITS: ☐ GR RECIPIENT ☐ V.A. ☐ SSI ☐ SSDI ☐ OTHER INCOME

☐ CLIENT SERVED IN THE MILITARY

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE: _____ PHONE: ( ) _____

CONSERVATOR ? ☐ YES ☐ NO NAME: _____ PHONE: ( ) _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ APS ☐ Probation ☐ DMH ☐ Regional Center

If Individual was referred to any other programs, please identify: _____

_____

_____

☐ Client is aware client has been referred to the FSP Program

FOCAL POPULATION

Individual's Name: _____

DMH IS#: _____

CHECK APPROPRIATE **REASON(S) FOR REFERRAL** OF AN OLDER ADULT WITH SERIOUS MENTAL ILLNESS:

1. ☐ Homelessness (# Number of Days Homeless over last 12 months _____)
   ☐ *Chronically Homeless (HUD Standards)
2. ☐ Incarceration (# of Incarcerated days over last 12 Months _____)
3. ☐ Hospitalization (# of acute psychiatric inpatient days _____)
4. ☐ At imminent risk of homelessness (e.g. at risk of eviction due to code violations)
5. ☐ Risk of going to jail (e.g. multiple interactions with law enforcement over 6 months or more)
6. ☐ Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home
7. ☐ Being released from SNF/ Nursing Home (What facility _____)
8. ☐ Presence of a Co-occurring disorder:
   - ☐ Substance Abuse
   - ☐ Developmental Disorder
   - ☐ Medical Disorder
   - ☐ Cognitive Disorder
9. ☐ Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated (e.g. APS- referred clients)
10. ☐ Serious risk of suicide (not imminent)
11. ☐ Current enrollment in an ACT/AB2034 program and is aging up in the system (ACT/AB2034 program _____)

Provide Detail for Any Checked Items: _____

*__Chronic Homeless HUD__: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has had 4 episodes of homelessness in the past three years.

LEVEL OF SERVICE

Individual's Name: _____

DMH IS#: _____

Check ONE ONLY:

☐ Unserved (Not receiving mental health services)
- ☐ History of mental health services, but none currently*
- ☐ No prior mental health services

☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
- ☐ FCCS ☐ Outpatient ☐ PEI ☐ Other: _____

☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

☐ Aggressive Ideation
☐ Aggressive Acts (by history or current)
☐ Aggressive Threats (by history or current)
☐ Fire Setting Ideation or Acts
☐ Inappropriate Sexual Ideation
☐ Inappropriate Sexual Acts
☐ Psychiatric Hospitalizations (Indicate dates below)
☐ Suicidal Ideation/Attempts
☐ Symptoms of Psychosis
☐ Tarasoff Notifications (past or current)
☐ Other _____

Provide Detail for Any Checked Items: _____

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit Coordinator**:

Veronica Quintana **(213) 738-3492**
Carol Sagusti **(213) 738-3492**

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DISPOSITION

Individual's Name: _____

DMH IS#: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: ( ) _____

Service Area: _____ Supervisorial District: _____ Fax: ( ) _____

Impact Unit Representative: _____ **Date:** _____

(**Fax** completed Referral and Authorization Form to **Impact Unit** for your Service Area)

TO BE COMPLETED BY FSP AGENCY

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL**

☐ **AGENCY DECLINES TO ENROLL, BUT INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP SERVICES** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES *AND* NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

PREVIOUS FSP ENROLLMENT WITHIN 365 DAYS ☐ **YES** ☐ **NO** **AGENCY** _____

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on _____ by _____

Date — Impact Unit Representative