COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP DISENROLLMENT REQUEST FORM

(To be use ONLY if Client has been enrolled in FSP with FSP services rendered and claimed in the Integrated System)

DATE: _____ ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

Agency: _____ Prov. #: _____ SA: ___ Contact Person: _____

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

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

ENROLLMENT DATE: _____ **REQUESTED DISENROLLMENT DATE:** _____

Reason for Disenrollment (Check ONE Only - Must Send Supporting Documentation):

☐ Target population criteria are not met. Briefly Explain: _____

☐ Client decided to discontinue Full Service Partnership participation after Partnership established.

☐ Client moved to another county/service area. **Aftercare Arrangements:** Briefly describe any referrals made or any linkages to ongoing care. Include date of referral, facility name, contact name and phone number:

☐ After repeated attempts to contact Client, Client cannot be located.
►Date of last face-to-face contact: _____
►Date of last check of DMH IS: _____
►Date of last check of jail/juvenile justice system: _____

Outreach Efforts: Briefly describe your attempts to locate client. Make reference to progress notes that document your efforts:

☐ Community services/program interrupted – Client's circumstances reflect a need for residential/institutional mental health services at this time (such as, IMD, MHRC, State Hospital).

☐ Community services/program interrupted – Client will be detained in juvenile hall or will be serving camp/ranch/CYA/jail/prison sentence.

☐ Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropriate. (Please include a copy of the Client Care & Coordination Plan and summary of how the goals were met.)
In addition to the statement above, please check box if statement below applies.
☐ Client no longer meets criteria for FSP. Their goals can be achieved at a lower level of service.

☐ Client deceased Date of death: _____

Impact Unit Decision

IU Signature _____ Date _____ ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Countywide Programs Decision

CW Programs Signature _____ Date _____ ☐ AUTHORIZED ☐ NOT AUTHORIZED*

NOTE: Upon Countywide's authorization to disenroll, Agency is responsible for closing the FSP episode in the integrated system, but ONLY after the final OMA assessment has been completed.

***Requires completion of Supplemental Form**