COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP TRANSFER REQUEST FORM

☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

(If transfer between age groups, please check the receiving age group above as your selection)

DATE: _____

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

Phone: _____ Fax: _____ E-mail: _____

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

ENROLLMENT DATE: _____ **REQUESTED TRANSFER DATE:** _____

NEW/RECEIVING PROGRAM/AGENCY: _____ Prov. #: _____ SA: ____

New Address: _____ City _____ Zip: _____

Contact Person: _____ Phone: _____

Reason for Transfer (Check ONE Only):

- ☐ Client requested a transfer.
- ☐ Client has moved out of Service Area.
- ☐ Client has moved within Service Area but closer to another FSP agency.
- ☐ Client's Linguistic/cultural needs.
- ☐ Client aged out of current services and/or client's clinical needs are better served by other age group.

AGE GROUP TRANSFERRING FROM: ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

- ☐ Other: _____

Briefly explain checked reason for transfer:

FSP Provider Acknowledgement

Current FSP Provider _____ Date _____ Receiving FSP Provider _____ Date _____

Impact Unit Decision

☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED* ☐ PRE-AUTHORIZED ☐ NOT PRE-AUTHORIZED*

Current IU Signature _____ Date _____ Receiving IU Signature _____ Date _____

Countywide Programs Decision

☐ AUTHORIZED ☐ NOT AUTHORIZED* ☐ AUTHORIZED ☐ NOT AUTHORIZED*

If Age Group Transfer:

Current CW Signature _____ Date _____ Receiving CW Signature _____ Date _____

*Requires completion of Supplemental Form