COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP TRANSFER REQUEST FORM

Child/Young Adult IFCCS Wrap Child Adult AOT

DATE: _______________ **(Please check the RECEIVING age group above as your selection)**

Agency: ______________________________________Prov. #: _________SA:_____ Contact Person: ______________________

Phone: ____________________________ Fax:__________________________ E-mail: _____________________________

CLIENT LAST NAME: ___________________________ **CLIENT FIRST NAME:** ___________________________ **DOB:** ______________________ **SSN:** ______________________ **DMH IBHIS#:** ______________________

Clients Preferred Language___________________________ **ENROLLMENT DATE:** ______________________

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.
- ☐ Other: ____

Briefly explain checked reason for transfer: (Include clinical needs).

For IFCCS/WRAP Child Transfers ONLY

Caregivers Name ____ Phone Number__________________________

Preferred Language _________________________ Email ____

Caregivers Address ____

CSW Name________________________________ Phone Number__________________ Email_______________________

Child FSP Navigator______________________________________ Email____

IFCCS Clinical Lead______________________________________ Email____

WRAP FSP Liaison_______________________________________ Email____

Experienced 2 or more placements in last 24 months? ☐ Yes ☐ No

Last CFT Date _________________

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.