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 _____ **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.)

☐ 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**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP TRANSFER REQUEST FORM

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 TRANSFER DATE:** _____

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

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.
- ☐ Other: _____

Briefly explain checked reason for transfer: _____

_____

_____

Impact Unit Decision

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

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

Countywide Programs Decision

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

*Requires completion of Supplemental Form

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP DISENROLLMENT/TRANSFER REQUEST SUPPLEMENTAL FORM

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

↓↓TO BE COMPLETED BY IMPACT UNIT↓↓

☐ **NOT PRE-AUTHORIZED FOR DISENROLLMENT/TRANSFER**
(Explain reason for decision and indicate status of client):

_____

_____

_____

_____

_____

_____

Impact Unit Representative: _____ Date: _____

↓↓TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION↓↓

☐ **NOT AUTHORIZED FOR DISENROLLMENT/TRANSFER**
(Explain reason for decision and indicate status of client):

_____

_____

_____

_____

_____

_____

Countywide Programs Representative: _____ Date: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP APPEAL FORM

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

Agency: _____ Contact Person: _____

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

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

Reason for Appeal (Check ONE Only):

☐ DMH Impact Unit has referred an eligible client to our agency that we decline to enroll.

☐ Our agency has requested authorization to enroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to enroll.

☐ Our agency has requested authorization to disenroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to disenroll.

☐ Our agency has requested authorization to transfer a client between FSP programs and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to transfer.

Explain Reason for Appeal: _____

Fax completed Appeal Form and copy of denied request to appropriate **Service Area District Chief.**

↓↓TO BE COMPLETED BY SERVICE AREA DISTRICT CHIEF↓↓

District Chief Name: _____ Service Area: _____

Phone: ( ) _____ Fax: ( ) _____

DISPOSITION: ☐ APPEAL APPROVED ☐ APPEAL DENIED

Explain Reason for Decision: _____

Service Area District Chief Signature: _____ Date _____

Countywide District Chief Signature: _____ Date _____