RMD Bulletin

Knowledge is power…

Verifying CalWORKs & GROW Benefits

As part of welfare reform in California, funds have been specifically budgeted for mental health services for participants who have an emotional barrier to employment. The Los Angeles County Department of Mental Health (DMH) and their contractors provide the mental health services to California Work Opportunity and Responsibility to Kids (CalWORKs) and General Relief Opportunities for Work (GROW) participants as part of an agreement with the Department of Public Social Services (DPSS) to assist County residents in returning to the workforce.

Revenue Management Division (RMD) would like to clarify that when conducting the financial screening process for clients with CalWORKs or GROW, a Notice of Action (NOA) letter is **NOT** needed to show proof of receiving CalWORKs or GROW. The only documentation needed would be the CalWORKs Clinical Assessment Provider Referral form or the Supportive Services Referral MHS form for GROW participants. Examples of these forms are attached to this bulletin for your reference.

We're here to help you...

If you have any questions or require further information, contact RMD at (213) 480-3444 or via e-mail at RevenueManagement@dmh.lacounty.gov.

DOES NOT APPLY TO FEE-FOR-SERVICE PROVIDERS

CalWORKs

CLINICAL ASSESSMENT PROVIDER REFERRAL

(Participant=s Name and Address)	(CalWORKs District or GAIN Regional Office)

IMPORTANT APPOINTMENT NOTICE

The following appointment has been scheduled for you to attend a clinical assessment for:

☐ Mental Health ☐ Substance Abuse

On:_____ at _____ Location:
Date Time

Address:

Phone#

It Is Important For You to Keep This Appointment. Bring This Notice With You.
If, For Any Reason You Cannot Keep This Appointment or Have a Problem, Please Contact Me Immediately.

GAIN Services Worker:	File No:	Telephone # ( )

GN 6006A (Revised 9/99)

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs CLINICAL ASSESSMENT RESULTS

(CalWORKs District or GAIN Regional Office)

Attention: _____
GSW Name/Number

Section A - Completed by GSW

Participant Name:		CalWORKs Case Number:
Residence Address:		Mailing Address:
Primary Language:	Birthdate:	Sex: ( )M ( )F
Telephone Number:		Social Security Number - -

Section B - Completed by Assessor (Complete and return to the GAIN Services Worker within 5 days)

Results of the assessment appointment: **Immediate Need** ☐

- ☐ Participant did not appear/complete the assessment
- ☐ Participant completed the assessment but does not need a referral for treatment
- ☐ Participant completed assessment & needs a referral but does not agree to treatment for ☐MH ☐SA
- ☐ Participant completed assessment and agrees to recommended treatment for ☐MH ☐SA
- ☐ Participant completed assessment does not agree, requests third party assessment. ☐MH ☐SA

DIRECT REFERRAL MADE FOR: ☐MH ☐SA
(If a direct referral is made fax this form and a copy of the GN6006B, Service Provider Referral Form to the GSW immediately).
Comments:

Assessor:	Facility Name:	Phone:

Section C - Completed by GAIN Participant

I authorize the release of information to DPSS regarding the results of my assessment and possible need for treatment services and agree to the service plan developed.

_____ _____
GAIN Participant's Signature Date

GN 6006A (Rev 10/98)

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

GENERAL RELIEF OPPORTUNITIES FOR WORK

SUPPORTIVE SERVICES REFERRAL MHS

GROW SITE:
CASE NAME:
CASE NUMBER:
GCM FILE NUMBER:
TELEPHONE NUMBER:

You have been scheduled for a supportive services appointment for:

❒ Mental Health Services

Please report to the facility at the date and time listed below.

SECTION A (POPULATED BY MAPPER)

_____
FACILITY NAME/LOCATION

_____ _____
DATE TIME

SECTION B (TO BE COMPLETED BY SERVICE PROVIDER)

(Complete and return to GROW Case Manager within five business days following the appointment date)

❒ PARTICIPANT FAILED TO SHOW FOR APPOINTMENT

❒ PARTICIPANT SHOWED FOR APPOINTMENT

❒ FURTHER SERVICES ARE NOT REQUIRED

❒ PARTICIPANT ASSESSED AS NSA, SEND ABP 296 TO NOTIFY ELIGIBILITY WORKER

❒ TREATMENT BEGAN ON _____

❒ EXPECTED DURATION _____

❒ HOURS PER WEEK REQUIRED _____

NAME OF PERSON COMPLETING FORM:	TITLE:

GROW CASE MANAGER:	TELEPHONE NUMBER:	FAX NUMBER:	DATE:

COUNTY OF LOS ANGELES

DEPARTMENT OF PUBLIC SOCIAL SERVICES

GENERAL RELIEF OPPORTUNITIES FOR WORK

SUPPORTIVE SERVICES REFERRAL MHS

GROW SITE:
CASE NAME:
CASE NUMBER:
GCM FILE NUMBER:
TELEPHONE NUMBER:

You have been scheduled for a supportive services appointment for:

☐ Mental Health Services

Please report to the facility at the date and time listed below.

SECTION A (POPULATED BY MAPPER)

_____ FACILITY NAME/LOCATION
_____ DATE _____ TIME

SECTION B (TO BE COMPLETED BY SERVICE PROVIDER)
(Complete and return to GROW Case Manager within five business days following the appointment date)

☐ PARTICIPANT FAILED TO SHOW FOR APPOINTMENT

☐ PARTICIPANT SHOWED FOR APPOINTMENT

☐ FURTHER SERVICES ARE NOT REQUIRED

☐ TREATMENT BEGAN ON: _____

☐ EXPECTED DURATION: _____

☐ HOURS PER WEEK REQUIRED: _____

NAME OF PERSON COMPLETING FORM:	TITLE:

GROW CASE MANAGER:	TELEPHONE NUMBER:	FAX NUMBER:	DATE: