Attachment C

If your clinic is unable to accept a MHLA patient referral for clinical reasons, please have your physician fill out this form and email it to: ReturnLinkageForms@dhs.lacounty.gov.

Affidavit of Community Partner's inability to accept patient referral due to clinical reasons		
I,	(Name of physician or PCP)	
of	(Name of Community Partner)	
(Name of clinic site)	(Address of clinic site)	(City of clinic site)
Do hereby certify that the following individual,	(Name of referred individual)	
is not a clinically appropriate referral to this clinic and that there are no providers at this clinic that have the clinical capacity to care for this patient for the following reason (s):		
(State the clinical reason(s) for inability to accept referral of this patient)		
I hereby affirm that I am not making this decision under pressure from another party. The individual was referred for care by the Department of Health Services to above-named Community Partner on: _____. (Enter date referred individual was referred to medical home clinic)		

Signature of Physician:		Date:	
Physician Printed Name:		Phone:	