DHS/DMH/LAHSA REFERRAL FORM FOR INTERIM HOUSING

The information provided below will be used to determine program eligibility and the most appropriate housing resource.

REFERRING ENTITY INFORMATION

Date of Referral: _____ Name of Referring Entity: _____

Referring Staff Name: _____ Referring Staff Title: _____

Referring Staff Phone Number: _____ Referring Staff Email Address: _____

Alternate Contact Name: _____ Alternate Contact Title: _____

Alternate Contact Phone Number: _____ Alternate Contact Email Address: _____

Referring Entity Type:

☐ Private Hospital ☐ Private Non-DHS Urgent Care ☐ Jail/Custody Setting (Non-ODR) ☐ Skilled Nursing Facility

☐ CBEST Program ☐ Mental Health Outpatient Treatment Facility ☐ Substance Use Disorder Residential Treatment Facility

☐ Substance Use Disorder Outpatient Treatment Facility (including Withdrawal Management Program) ☐ CARE Court

☐ Street-Based Outreach Program, specify: ☐ LAHSA Outreach Team ☐ DMH Outreach Team ☐ DHS Outreach Team

If Street-Based Outreach Program, select Outreach Team name.

☐ SPA 1 - MHA LA	☐ SPA 4 - C3 Skid Row Team (Blue)	☐ SPA 5 - St. Joseph Center
☐ SPA 1 - LAFH	☐ SPA 4 - The People Concern	☐ SPA 6 - HOPICS
☐ SPA 2 - LAFH	☐ SPA 4 - The Center at Blessed Sacrament	☐ SPA 6 - SSG MLK Campus
☐ SPA 2 - SFVCMHC, Inc.	☐ SPA 4 - Homeless Health Care LA	☐ SPA 6 - SSG CD8
☐ SPA 3 - USHS	☐ SPA 4 - Exodus Recovery NELA	☐ SPA 7 - PATH
☐ SPA 4 - C3 Skid Row Team (Red)	☐ SPA 4 - Exodus/LAC + USC Team	☐ SPA 8 - MHA LA
☐ SPA 4 - C3 Skid Row Team (Purple)	☐ SPA 5 - C3 Venice Team	☐ SPA 8 - Harbor UCLA Campus Team
☐ SPA 4 - C3 Skid Row Team (Yellow)	☐ SPA 5 - C3 Santa Monica Team	☐ PATH Metro Team

☐ Other, specify: _____

☐ DHS ICMS Provider and participant is not being served by one of the above entities.

☐ Victim Service Provider, specify: _____

☐ Other referring entity, specify: _____

PARTICIPANT INFORMATION

Participant Name (First, Middle, Last): _____ DOB: _____ Age: _____

Social Security # (if known): _____ Medical Record #: _____

*Required if Social Security # unknown:

*Participant Maiden Name _____ *Place of Birth _____

HMIS# (if known): _____ CHAMP ID # (if known): _____ IBHIS # (if known): _____

CES Acuity Score: _____ CES Score is for a: ☐ Youth/Adult ☐Family Matched to Housing Resource? ☐ Yes ☐ No

Participant Demographics

Race and Ethnicity: (Select all that apply)
☐ American Indian, Alaskan Native, Indigenous ☐ Black, African American, or African ☐ Asian or Asian American
☐ Hispanic/Latina/e/o ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander
☐ White ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Gender Identity:
☐ Man (Boy if child) ☐ Woman (Girl if child) ☐ Transgender ☐ Non-Binary ☐ Questioning
☐ Culturally Specific Identify (e.g., Two-Sprits) ☐ Different Identity, specify: _____
☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Indicate the participant's gender bed preference:
☐ Male ☐ Female ☐ No Preference

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____

Sexual Orientation:
☐ Asexual ☐ Pansexual ☐ Queer ☐ Straight/heterosexual
☐ Gay or Lesbian ☐ Bisexual ☐ Questioning ☐ Other _____

Have you served in the US Armed Forces? ☐ Yes ☐ No ☐ Client doesn't know ☐ Clients prefers not to answer ☐ Data not collected

Primary Language Spoken: _____ Limited English proficiency requiring translation services? ☐ Yes ☐ No

Participant Phone Number: _____ Participant Email Address: _____

Participant Name: _____ **HMIS/CHAMP/IBHIS ID#:** _____

PARTICIPANT INFORMATION

Participant Current Location:

☐ SPA 1 - Antelope Valley ☐ SPA 2 - San Fernando Valley ☐ SPA 3 - San Gabriel Valley ☐ SPA 4 - Metro LA (Non Skid Row)

☐ SPA 4 – Skid Row Only ☐ SPA 5 - West LA ☐ SPA 6 - South LA ☐ SPA 7 - South East LA ☐ SPA 8 - South Bay/Long Beach

Specify address including city and zip code or cross streets where participant typically resides (Information required for placement options): _____

Is the participant chronically homeless (Experienced homelessness for 365 consecutive days or longer, or experienced at least four episodes of homelessness in the last three years that total a year or longer)? ☐ Yes ☐ No

If no, length of Homelessness (Months) ☐ <2 ☐ 2-3 ☐ 4-6 ☐ 7-9 ☐ 10-11

How was chronic/length of homelessness verified? ☐ HMIS ☐ 3rd Party Certification ☐ Participant Self-Reported

Is the participant currently connected to an Office of Diversion and Re-entry (ODR) funded program?

☐ Yes ☐ No If yes, specify the name of the program and provider: _____

Is the participant currently in law enforcement custody, due to the lack of housing, while awaiting an upcoming trial or court hearing?

☐ Yes ☐ No If yes, specify the anticipated discharge date: _____

Did the participant exit an institution within the last 90 days? ☐ Yes ☐ No If yes, specify the discharge date: _____

Select type of Institution: ☐ Jail/Prison ☐ Hospital ☐ Emergency Room ☐ Substance Use Treatment Facility

☐ Foster Care ☐ Detention Center ☐ Residential Care Facility

Is the participant conserved or does the participant have a conservatorship hearing pending? ☐ Yes ☐ No

If yes, type of conservatorship: ☐ LPS ☐ Probate

Other Considerations: ☐ AB109 Probation ☐ Convicted of Arson ☐ Registered Sex Offender ☐ Veteran ☐ N/A

Fleeing/attempting to flee: ☐ Domestic Violence ☐ Human Trafficking or Sex Trafficking ☐ Sexual Assault ☐ N/A

HOUSEHOLD INFORMATION

(Only complete if the participant is requesting to be housed with family)

Minor Children

Name: _____ DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other Legal Custody: ☐ Yes ☐ No

Name: _____ DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other Legal Custody: ☐ Yes ☐ No

Name: _____ DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other Legal Custody: ☐ Yes ☐ No

Name: _____ DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other Legal Custody: ☐ Yes ☐ No

Name: _____ DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other Legal Custody: ☐ Yes ☐ No

(If there are more minor children to be housed with participants, provide the above-requested information in the "Additional Information" section below.)

Additional Adults in Household

Name: _____ DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other Qualified Dependent*: ☐ Yes ☐ No

Name: _____ DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other Qualified Dependent*: ☐ Yes ☐ No

*Qualified dependents are over age 18, incapable of employment due to mental/physical disability, and dependent upon the participant for financial support. (If there are more adult individuals to be housed with participants, provide the above-requested information in the "Additional Information" section below.)

Is the participant pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Are any other members of the household pregnant? ☐ Yes ☐ No If yes, what relationship to the participant? _____

Additional Information: _____

PRESENTING ISSUE(S)

Select all that apply to the participant.

☐ Medical: ☐ Mental Health: ☐ Recent Substance or Substance Use ☐ Cognitive Impairments:

☐ The participant does not have any of the above issues.

Participant Name: _____ **HMIS/CHAMP/IBHIS ID#:** _____

TUBERCULOSIS (TB) SCREENING

1. Has the participant had a cough recently that has lasted longer than 3 weeks? ☐ Yes ☐ No ☐ Don't Know
2. Has the participant recently lost weight without explanation during the past month? ☐ Yes ☐ No ☐ Don't Know
3. Has the participant had frequent night sweats during the past month, soaking their sheets or clothing? ☐ Yes ☐ No ☐ Don't Know
4. Has the participant coughed up blood in the past month? ☐ Yes ☐ No ☐ Don't Know
5. Has the participant been feeling much more tired than usual over the past month? ☐ Yes ☐ No ☐ Don't Know
6. Has the participant had fevers almost daily for more than one week? ☐ Yes ☐ No ☐ Don't Know

If the participant has a prolonged cough (> 3 weeks) AND answers yes to any other TB screening question, the participant must be promptly referred to a healthcare provider for an evaluation.

TB Test Performed: ☐ Yes ☐ No Date Completed: _____ Results: _____

Chest X-Ray Performed: ☐ Yes ☐ No Date Completed: _____ Results: _____

ADDITIONAL PARTICIPANT/HOUSEHOLD INFORMATION

Select all that apply to the participant.

☐ Needs assistance with Activities of Daily Living (i.e., bathing, dressing, transferring, toileting, eating)
☐ Has caregiver support
☐ Incontinent of bladder or bowel and independent with the use of incontinence supplies
☐ Needs caregiver support
☐ Respiratory issues requiring an oxygen tank
☐ Cannot transfer (e.g., from wheelchair to bed)
☐ Cannot climb stairs
☐ Independently uses walker/cane/crutches
☐ Independently uses a motorized wheelchair
☐ Significant visual impairment
☐ Independently uses a manual wheelchair
☐ Significant auditory impairment
☐ Needs bottom bunk
☐ Other additional information, specify: _____

Does any of the above apply to other household members being placed with the head of the household? If yes, specify: _____

_____

Does the participant/household have any animal(s) that will accompany them into Interim Housing?

☐ Yes ☐ No If yes, complete questions 1-3 below.

1. Is the animal a service animal? ☐ Yes ☐ No If yes, # of animals: _____ Type(s): _____ Weight: _____
2. Is the animal an emotional support animal? ☐ Yes ☐ No If yes, # of animals: _____ Type(s): _____ Weight: _____
3. Is the animal a pet? ☐ Yes ☐ No If yes, # of animals: _____ Type(s): _____ Weight: _____

CURRENT SLEEPING/LIVING ARRANGEMENT

Select the category that best describes the participant's current sleeping/living arrangement.

☐ Sleeping in a place not meant for human habitation, specify:
☐ Street ☐ Park ☐ Campground ☐ Vehicle ☐ Other, specify: _____

☐ Shelter/Interim Housing (Shelter Name: _____)

Shelter Funder: ☐ LAHSA ☐ DMH ☐ DHS ☐ VA ☐ Other ☐ Unknown

☐ Hotel/Motel fully or partially subsidized by a public or non-profit agency

☐ Exiting an institution (Jail/Prison, Foster Care, Detention Center, Residential Care Facility, or Substance Use Treatment Facility) where the participant has resided for:
☐ 90 days or less
☐ For more than 90 days AND participant resided in Shelter/Interim Housing, or a place not meant for human habitation before entering the institution

☐ Staying temporarily with family/friends

☐ Recent eviction/relinquishing unit to prevent eviction Date of eviction/unit relinquished: _____

☐ Other sleeping/living arrangements, specify: _____

Participant Name: _____ **HMIS/CHAMP/IBHIS ID#:** _____

INTERIM HOUSING PLACEMENT LOCATION

1. Is the participant willing to reside in a congregate living environment? ☐ Yes ☐ No (Most Interim Housing sites are congregate living environments.)
2. Is the participant willing to reside in the Skid Row area? ☐ Yes ☐ No
3. Is the participant willing to sleep on a top bunk of a bunk bed? ☐ Yes ☐ No
4. Is there any SPA(s) where the participant would prefer to live in Interim Housing? Select all that apply.

☐ SPA 1 - Antelope Valley ☐ SPA 2 - San Fernando Valley ☐ SPA 3 - San Gabriel Valley ☐ SPA 4 - Metro LA

☐ SPA 5 - West LA ☐ SPA 6 - South LA ☐ SPA 7 - South East LA ☐ SPA 8 - South Bay

5. Is there any city/cities where the participant would prefer to live in Interim Housing? ☐ Yes ☐ No If yes, specify: _____

_____

6. Does the participant have an Interim Housing provider(s) preference? ☐ Yes ☐ No If yes, specify: _____

_____

7. Is the participant willing to go to an alternate provider? ☐ Yes ☐ No
8. Is there any SPA(s) where the participant **CAN NOT** live in Interim Housing? Select all that apply.

☐ SPA 1 - Antelope Valley ☐ SPA 2 - San Fernando Valley ☐ SPA 3 - San Gabriel Valley ☐ SPA 4 - Metro LA

☐ SPA 5 - West LA ☐ SPA 6 - South LA ☐ SPA 7 - South East LA ☐ SPA 8 - South Bay

9. Is there any city/cities where the participant **CAN NOT** live in Interim Housing?

☐ Yes ☐ No If yes, specify: _____

Additional Required Document Acknowledgement

For referrals submitted to DMH or DHS, check that the below-required documents are included with the referral submission. This is not applicable to referrals submitted to LAHSA.

DMH

☐ Los Angeles County Department of Mental Health Authorization for Use or Disclosure of Protected Health Information
☐ Supplemental Form (Attachment A) for Interim Housing for participants that meet any of the Participant Review criteria on page 1

DHS

☐ Notice Of Privacy Practices Acknowledgment Form
☐ Supplemental Form (Attachment A) for Interim Housing
☐ DHS Authorization for the Use and Disclosure of Health and Social Service Information (New Universal Consent Form)