COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

ADULTS (AGES 26-59) & FORENSIC FULL SERVICE PARTNERSHIP AUTHORIZATION/NOTIFICATION FORM

CLIENT INFORMATION

FSP PROGRAM: (check one)

☐ **ADULT**
☐ **FORENSIC**

***Insufficient details may delay referral process**

DMH IS/IBHIS#: _____

DATE: _____ **SSN:** _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY:** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **OTHER**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **MEDICARE** ☐ **NONE** ☐ **PRIVATE:** _____

BENEFITS: ☐ **GR RECIPIENT** ☐ **V.A.** ☐ **SSI** ☐ **SSDI** ☐ **OTHER INCOME:**

☐ **CLIENT SERVED IN THE MILITARY** **CONSERVATOR?** ☐ **YES** ☐ **NO** **NAME:** _____

PHONE: ( ) _____

PRIMARY CONTACT: _____ **PHONE:** ( ) _____

RELATIONSHIP: _____

REFERRAL SOURCE

Agency: _____ Provider # (if applicable): _____ Service Area: _____

Contact Person: _____ Phone: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ Probation ☐ APS ☐ GR/DPSS ☐ Parole: ☐ Revocable (Client is not eligible for services) ☐ Non-Revocable

If Individual was referred to any other programs, please identify: _____

FSP Agency Representative: _____

☐ Client is aware that an FSP referral has been made on his/her behalf.

FOCAL POPULATION

Individual's Name: _____

DMH IS/IBHIS#: _____

Check either A. or B.

If the client meets the focal population for section A., the referral requires authorization.
If the client meets the focal population for section B., the referral is considered a notification.
In the event the client meets the criteria for both A. and B., the referral requires authorization.

A. ☐ **AUTHORIZATION FOR ENROLLMENT**
B. ☐ **NOTIFICATION FOR ENROLLMENT** **ENROLLMENT DATE:** _____

A. CHECK APPROPRIATE REASON(S) FOR REFERRAL:

	# Days during last 12 months	# Episodes in last 12 months
☐ Homeless ☐ [1]Chronically Homeless (HUD Standards)		
☐ Jail		
☐ Institution(s) (mark all that apply):		
☐ Institution for Mental Disease		
☐ State Hospital		
☐ Psychiatric Emergency Services		
☐ Urgent Care Center		
☐ County Hospital		
☐ Fee for Service Hospital		

Name of Acute/Long Term Psychiatric Facilities: _____

☐ Living with family members without whose support the individual should be at Imminent Risk of Homelessness, jail or institutionalization.
Specify: _____

Document any pertinent outreach information regarding client here: (Ex. Client is difficult to engage, client prefers female staff, language barriers, etc.)

B. CHECK APPROPRIATE REASON(S) FOR NOTIFICATION: **ENROLLMENT DATE:** _____

☐ At risk of becoming homeless (History of destruction of property, unable to maintain living arrangement, ongoing conflict with neighbors and/or landlord, etc.)
☐ At risk of becoming involved with the criminal justice system (Unable to pay fees, presence of warrants, two or more contacts with law enforcement in the past 90 days, etc.)
☐ At risk of being psychiatrically hospitalized (Two or more visits to a psychiatric urgent care center, medical emergency room for a psychiatric disorder, or psychiatric emergency room in the past 90 days or at least one encounter with an emergency outreach team in the past 90 days, etc.)

Provide additional details

[1]Chronic Homeless HUD: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has 4 episodes of homelessness in the past three years.

LEVEL OF SERVICE

Individual's Name: _____

DMH IS/IBHIS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ Recovery, Resilience & Reintegration Services ☐ PEI ☐ Other: _____
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

DSM-5/ICD-10 Code: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Other _____
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatric Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)

Provide Detail for Any Checked Items:

_____

_____

_____

Fax completed Pre-Authorization/Notification Form to **Impact Unit** for your Service Area:

SA 1: Angela Coleman	(661) 537-2937	SA 5: Kim Phan	(310) 313-0813	SA 8: Trisha Deeter	(562) 290-1230
SA 2: Darrell Scholte	(818) 347-8736	SA 5: Samantha Howard	(310) 313-0813	SA 8: Jenny Nguyen	((562) 290-1230
SA 3: Eugene Marquez	(626) 331-0121	SA 6: Perla Cabrera	(213) 351-7747		
SA 4: Phyllis Moore Hayes	(213) 680-3225	SA 7: Alicia Ibarra	(213) 384-0729		

DISPOSITION

Individual's Name: _____

DMH IS/IBHIS#: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: (____) _____

Service Area: _____ Supervisorial District: _____ Fax: (____) _____

Impact Unit Representative: _____ **Date:** _____

(Fax completed Referral Form to **Impact Unit** for your Service Area)

TO BE COMPLETED BY FSP AGENCY

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL**

☐ **AGENCY DECLINES TO ENROLL, BUT INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP SERVICES** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES *AND* NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOTIFICATION ACKNOWLEDGED Date:** _____

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Program Representative: _____ **Date:** _____

PREVIOUS FSP ENROLLMENT WITHIN 365 DAYS ☐ **YES** ☐ **NO** **AGENCY** _____

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Program Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION ON: _____ (Date) by _____ (Impact Unit Representative)