PH ²

Prevent Homelessness Promote Health

DHS/DMH Collaboration

Physical/Mental Health Assistance Referral

REFERRING AGENCY CONTACT INFORMATION

Staff Name: ______________________ Supervisor: ______________________

Agency: ______________________ Date: ______________________

Staff Phone #: ______________________ Staff E-Mail: ______________________

CLIENT INFORMATION

Client Name: ______________________ DOB: ______________ Gender: ______________

SSN: ______________ Ethnicity: ______________ Primary Language: ______________

ORCHID ID: ______________________ CHAMP ID: ______________________

Client is in permanent housing? ☐ Yes ☐ No Months in permanent housing: ______________

Client Address: ______________________ Service Area: ______

Client Phone #: ______________________ Other Client Contact Information: ______________________

REASON FOR REFERRAL: ☐ **PHYSICAL HEALTH** ☐ **MENTAL HEALTH**

PHYSICAL HEALTH INFORMATION

Client Health Insurance: ______________________ ID #: ______________ Expiration Date: ______________

Client PCP: ______________________ Location: ______________________

Clinic Phone #: ______________________ Care Manager Phone #: ______________________

Other Provider: ______________________ Specialty: ______________________

Location: ______________________ Clinic Phone #: ______________________

How many times has the client accessed the ER ***or*** inpatient care in the last 12 months (if known)? ______________

Date/Facility: ______________________ Date/Facility: ______________________

Date/Facility: ______________________ Date/Facility: ______________________

Date/Facility: ______________________ Date/Facility: ______________________

Is the client making regular visits to a primary care physician? ☐ Yes ☐ No

If No, why is the client not accessing primary care services? ______________________

____

Is the client currently prescribed any medications? ☐ Yes ☐ No

List all medications ____

____

Is the client compliant with the prescribed medication plan? ☐ Yes ☐ No

If No, is the client's health worse due to poor medication adherence? ☐ Yes ☐ No

SUBMIT REFERRAL TO: PHsquared@dmh.lacounty.gov **AND** HFHmedicalcasemanagement@dhs.lacounty.gov

MENTAL HEALTH INFORMATION

Is the client currently receiving mental health services? ☐ Yes ☐ No ***If Yes,*** IBHIS #: ____________________

Check all descriptions that apply to the client:

☐ Age 16-25 ☐ 65 years or older ☐ Family Unit ☐ Single Adult ☐ Veteran ☐ Other, specify: ____________

Check all concerns/tenant violations and list dates:

☐ Substance Abuse ☐ Legal ☐ Destruction of Property ☐ Hoarding ☐ Relationship Conflicts

☐ Infestation ☐ Fire Safety/Health Hazard ☐ Aggressive/Violent Behavior ☐ Failure to Pay

☐ Other ____

Is eviction in process? ☐ Yes ☐ No

Have there been or are there currently any safety issues? ☐ Yes ☐ No

If Yes, describe: ____

SERVICES NEEDED

☐ Assessment of Higher Level of Care/ In-Home Caregiving (IHCG)/ In-Home Supportive Services (IHSS)

☐ Medication Review/Adherence Support (Short-Term)

☐ Physical Health Assessment and Short-Term Support/Linkage

☐ SUD Assessment and Short-Term Support/Linkage

☐ Mental Health Assessment and Short-Term Support/Linkage

☐ Functional Assessment and Short-Term Support/Linkage

☐ Assistance with Housing Accommodations

☐ Other (please see attached sheet for details)

NOTE: PSH RNs cannot do blood draws or 5150 holds.

ICMS is responsible for doing routine accompaniments and transitions of care as well as ensuring that clients have active health insurance and are empaneled to primary care. ICMS is also responsible for housing and social services support (food, transportation, etc.), M-F only.

ADDITIONAL INFORMATION RELEVANT TO THIS REQUEST

***If eligible for assistance, HFH Nursing staff OR DMH will contact agency staff. HFH OR DMH Program Manager will inform agency staff if the participant is NOT eligible for assistance. ***

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