LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH (DMH)
ENRICHED RESIDENTIAL CARE (ERC) PROGRAM REFERRAL

REFERRING AGENCY/STAFF INFORMATION

Referral Date: _____ Program Type: ☐ FSP ☐ HOME ☐ ICD ☐ Outpatient ☐ PG ☐ Hollywood 2.0

Referring Agency: _____ Referring Staff Name: _____

Referring Staff Phone Number: _____ Referring Staff Email: _____

CLIENT INFORMATION

Client IBHIS #: _____ Client DOB: _____

Client Last Name: _____ Client First Name: _____

Client Gender: ☐ M ☐ F ☐ Trans Man ☐ Trans Woman ☐ Other Gender Identity, specify: _____

Where is client currently residing? _____ Is this a licensed residential facility? ☐ No ☐ Yes

Has client been homeless in the past 12 months? ☐ No ☐ Yes Is client exiting a higher level of care? (i.e., IMD, ERS, hospital) ☐ No ☐ Yes

Does client have mobility needs? ☐ No ☐ Yes, specify: _____

Does client have income? ☐ No ☐ Yes, source: _____ Monthly Amount $ _____

Does client have SSI application or appeal in progress? ☐ No ☐ Yes If yes, date of SSI application: _____

(NOTE: Clients receiving GR/CalFresh will be required to terminate these benefits if approved for the ERC program and, if eligible, apply for SSI.)

Has client been approved for admission by a **Licensed** Residential Facility? ☐ No ☐ Yes

- If yes, specify: Facility Name: _____

Facility Address: _____

Facility Contact: _____

Facility Contact Phone Number: _____ Facility Contact Email: _____

Was this placement made using MHRLN? ☐ No ☐ Yes

What agency will provide client with ongoing, **field-based services** once admitted to a Licensed Residential Facility?

☐ Referring Agency

☐ Other Agency, specify: Agency Name: _____

Agency Contact: _____

Agency Contact Phone Number: _____ Agency Contact Email: _____

Is this agency an FSP provider? ☐ No ☐ Yes If yes, type of FSP: ☐ Directly-Operated FSP ☐ Contracted FSP

If contracted FSP, does agency agree to pay SSI rate and P&I using Client Supportive Services (CSS) funding? ☐ No ☐ Yes

******Securely email completed forms to DMH_ERC@dmh.lacounty.gov ******

REFERRAL DISPOSITION
(TO BE COMPLETED BY DMH ERC STAFF ONLY)

Is client approved for ERC?

☐ No, specify reason: _____

☐ Yes, client is approved for: ☐ Rent Payment ☐ P&I Funds ☐ Enhanced Services Rate ☐ Community Care Expansion

ERC Staff Signature: _____ Date: _____

ERC Staff Name: _____ Expiration Date: _____

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institution Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to whom it pertains unless otherwise permitted by law.