

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH



**FULL SERVICE PARTNERSHIP
DISENROLLMENT/TRANSFER
REQUEST
SUPPLEMENTAL FORM**

CLIENT LAST NAME: _____ CLIENT FIRST NAME: _____ DOB: _____
SSN: _____
DMH IBHIS#: _____

↓↓ TO BE COMPLETED BY IMPACT UNIT ↓↓

NOT PRE-AUTHORIZED FOR DISENROLLMENT/TRANSFER
(Explain reason for decision and indicate status of client):

Impact Unit Representative: _____ Date: _____

↓↓ TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION ↓↓

NOT AUTHORIZED FOR DISENROLLMENT/TRANSFER
(Explain reason for decision and indicate status of client):

Countywide Programs Representative: _____ Date: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled