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: _____