CONFIDENTIAL

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

Community Assistance Recovery and Empowerment (CARE) Referral Form

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

***Please note that the CARE Program does not have the authority to mandate medication or involuntary long-term hospitalization and or LPS Conservatorship. Please email the completed referral to CareCourt@dmh.lacounty.gov**

REFERRAL /REPORTING PARTY

DATE COMPLETED: _____

NAME & DISCIPLINE: _____ AGENCY: _____ RELATION TO CANDIDATE: _____

PHONE: _____

EMAIL: _____ _____

CARE CANDIDATE INFORMATION

Attach recent photo here

SSN: _____

DMH IS#/IBHIS #: _____

LAST NAME: _____ FIRST NAME: _____ GENDER: _____

DOB: _____ HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____

ADDRESS: _____ CITY: _____ ZIP: _____

If chronically experiencing homelessness, please specify a known frequently visited location (e.g. corner of 6th/Vermont) (Required)

PHONE NUMBER: _____ PREFERRED LANGUAGE: _____ ☐ CANDIDATE SERVED IN THE U.S. MILITARY

RACE/ETHNICITY: ☐ WHITE/NON-HISPANIC ☐ HISPANIC ☐ NATIVE AMERICAN/ALASKAN ☐ AFRICAN AMERICAN ☐ ASIAN ☐ UNKNOWN/DECLINED TO STATE ☐ OTHER: _____

CURRENT LIVING SITUATION:

☐ HOMELESS ☐ HOMELESS SHELTER ☐ HOSPITAL ☐ HOUSING/APT ☐ JAIL/CORRECTIONAL FACILITY ☐ SOBRIETY FACILITY ☐ PSYCHIATRIC FACILITY ☐ WITH FAMILY/ADULT ☐ UNKNOWN ☐ SPECIFY AGENCY: _____

INSURANCE: CHECK ALL THAT APPLY

☐ MED-ICAL ☐ MEDICARE ☐ PRIVATE ☐ NONE ☐ OTHER/MEDICAL RECORD # _____ ☐ UNKNOWN

BENEFITS: CHECK ALL THAT APPLY AND INDICATE AMOUNTS

☐ GR RECIPIENT $ ____ ☐ V.A. $ ____ ☐ SSI $____ ☐ SSDI $ ____ ☐ PENDING ☐ UNKNOWN ☐ OTHER $_____ ☐ NONE

PROGRAM CRITERIA:

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

☐ YES ☐ NO IF YES, PROVIDER: _____ PHONE: _____

DSM V-TR Diagnosis:

SUBSTANCE ABUSE ☐ NEVER USED ☐ CURRENTLY USING ☐ PAST USE ☐ UNKNOWN AGE FIRST USED

LIST TYPE (S) OF SUBSTANCE ABUSED & FREQUENCY: _____

INDIVIDUAL RECEIVED SUBSTANCE ABUSE TREATMENT: ☐ YES ☐ NO TREATMENT PROGRAM _____

PHYSICAL HEALTH ISSUES AND MEDICATION(S): _____

MENTAL HEALTH MEDICATIONS (LIST ALL): _____

COMPLIANCE WITH MENTAL HEALTH MEDICATION

☐ TAKES MEDS REGULARLY ☐ SOMETIMES TAKES MEDS ☐ NEVER TAKES MEDS ☐ NO MEDICATIONS PRESCRIBED

☐ TAKES MEDS MOST OF THE TIME ☐ RARELY TAKES MEDS ☐ REFUSES MEDS ☐ UNKNOWN ☐ OTHER: _____

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CARE
CANDIDATE REFERRAL FORM

LOS ANGELES COUNTY
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NAME:_____
DMH IS#/IBHIS #: _____

TYPE OF SERVICES PROVIDED: _____

HAS THE INDIVIDUAL BEEN REFERRED TO THE FOLLOWING IN THE PAST? ☐ **FSP** ☐ **Outpt** ☐ ☐ **PRIVATE INSURANCE** ☐ **NONE**

	LIST DATES OF ADMISSION & DISCHARGE		REASON FOR ADMISSION/NAME OF FACILITY
NO. OF WIC 5250 Hosptializations MONTHS: _____			
NO. OF OTHER KNOWN SERVICES IN THE PAST 36 MONTHS: _____			

Please complete the information below in as much detail as possible, if more space is needed, please attach an additional sheet.

Describe candidate's **IMMEDIATE RISK & SAFETY CONCERNS** and most concerning behavior that occurred including danger to self and others

Describe how the candidate is **UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND IS AT RISK OF DETERIORATION** (e.g. unable to care for self or provide food, clothing, or shelter)

Describe the candidate's **HISTORY OF NON-COMPLIANCE WITH TREATMENT** (has been offered the opportunity to participate in treatment and fails to engage)