COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

INTENSIVE MENTAL HEALTH SERVICES REFERRAL FORM

DEMOGRAPHIC INFORMATION

Child/youth is being referred to: ☐ FSP (ages 0-15) ☐ IFCCS (ages 0-21)

Referral Date: _____ **IS / IBHIS #:** _____

SSN: _____

Last Name: _____ **First Name:** _____ **Gender:** _____

Preferred Language _____ **Ethnicity:** _____ **DOB:** _____ **Age:** ____

Insurance: ☐ Medi-Cal ☐ Indigent/None ☐ Third Party Payor

Current Living Situation: ☐ Home of Parent ☐ Relative ☐ Foster Home ☐ ESC ☐ TSC

☐ Group Home Facility Name: _____ Level: _____ ☐ Other: _____

Current Address: _____

City: _____ **Zip Code:** _____ **Phone:** _____

Primary Contact: _____ **Relationship:** _____

Primary Contact's Preferred Language: _____ **Phone:** _____

Conservator? ☐ No ☐ Yes **Name:** _____ **Phone:** _____

REFERRAL SOURCE

Contact Person: _____ **Agency:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

If you are an IFCCS Referral Portal, please identify your portal:

☐ Child/TAY ☐ CYCS Team (SB 82) ☐ DCFS High Risk Unit ☐ DMH D-Rate Assessment

☐ DMH Hospital D/C Unit ☐ DMH MAT ☐ DMH Wrap Liaison ☐ EOB

☐ Medical HUB ☐ SFC ☐ TSC ☐ UCC/Valley Coordinated

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ Regional Center

Please identify recent referrals: ☐ D-Rate ☐ RCL 12 or above ☐ TFC

☐ Wraparound ☐ Other: _____

☐ **Child/Family is aware a referral has been submitted to an intensive mental health program**

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.

DCFS INFORMATION

Individual's Name: _____

IS/IBHIS #: _____

DCFS Case: ☐ **Adoption** ☐ **ER Case** ☐ **Family Maintainence/Reunification**

☐ **New Detention** ☐ **Voluntary Case**

Assigned DCFS Office: _____

CSW Name: _____ **Phone:** _____ **E-mail:** _____

SCSW Name: _____ **Phone:** _____ **E-mail:** _____

If you are a DCFS referring party, please attach the following documents:

☐ Child Profile Report

☐ Consents (179)/Minute ☐ Court Report/Voluntary Case Report ☐ JV 220 (current) ☐ Placement History

LEVEL OF SERVICE

Check ONE ONLY:

☐ Unserved (Not receiving mental health services)

☐ History of mental health services, but none ☐ No prior mental health services

☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*

☐ PEI ☐ FCCS ☐ Outpatient ☐ Other: _____

☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

If client is currently receiving mental health services please indicate:

Therapist: _____ Agency: _____ Phone: _____

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

DIAGNOSTIC CONSIDERATIONS

Primary DSM-V Diagnosis: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

☐ Aggressive Acts (by history or current)
☐ Aggressive Ideation/Threats (by history or current)
☐ Contact with PMRT or Urgent Care
☐ Eating Disturbances
☐ Exposure to Trauma
☐ Fire Setting Ideations or Acts
☐ Hyperactive/Impulsive/Inattentive
☐ Psychiatric Hospitalization (indicate dates below)
☐ Suicidal Ideations/Attempts
☐ Symptoms of Psychosis
☐ Tarasoff Notifications (past or current)
☐ Other: _____

Provide details for any checked items:

FOCAL POPULATION

Individual's Name: _____

IS/IBHIS #: _____

CHECK APPROPRIATE REASON(S) FOR REFERRAL OF A CHILD OR YOUTH (AGE 0 - 21) WHO HAS A SERIOUS EMOTIONAL DISTURBANCE (SED)* AND AT LEAST ONE OF THE FOLLOWING:

1. Zero to five-year-old who:
   - ☐ is at risk of expulsion from pre-school
   - ☐ is at risk of removal or has been removed from the home by the Department of Children and Family Services (DCFS)
   - ☐ has a parent/caregiver with severe and persistent mental illness, or who has a substance abuse co-occurring disorder

2. Child/youth who:
   - ☐ has been removed or is at risk of removal from the home by DCFS
   - ☐ has a history of drug possession or use
   - ☐ is at risk of or currently involved with the juvenile justice system
   - ☐ is at risk of commercial sexual exploitation
   - ☐ is currently a victim of commercial sexual exploitation
   - ☐ has had three or more DCFS placements within the past 24 months

3. Child/youth unable to function in the home and/or community setting and:
   - ☐ is transitioning back to a less structured home or community setting
   - ☐ is at risk of becoming or is currently homeless

4. Child/youth experiencing the following at school:
   - ☐ truancy or sporadic attendance
   - ☐ suspension or expulsion
   - ☐ failing classes

Provide Detail for Any Checked Items:

*"Seriously emotionally disturbed" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either if the following occur:
   (i) The child is at risk of removal from home or has already been removed from the home.
   (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment. treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. [California Welfare and Institutions Code Section 5600.3]

If referring to FSP, fax completed Referral and Authorization Form to your Service Area **Impact Unit** :

SA 1: Salem Redding	(661) 537-2937	SA 4: Suyapa Umanzor	(213) 680-3225	SA 8: April Hagerty	(562) 290-1230
SA 2: Colin (Fang) Xie	(818) 347-8738	SA 5: Jeong Min Rhee	(310) 313-0813		
Luz Smith		SA 6: Dana Calloway	(213) 351-7747		
SA 3: Vanessa Torres	(626) 331-0121	SA 7: Cheryl Lopez	(213) 384-0729		

If referring to IFCCS, email completed Referral and Authorization Form to **CSOCIFCCS@dmh.lacounty.gov**

FSP DISPOSITION

Individual's Name _____

IS/IBHIS #: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT:** (Explain reason for decision and plan for linkage to other services)

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider #: _____

FSP Agency Address: _____ City: _____ ZIP Code: _____

Contact Person: _____ Phone: ( ) _____

Service Area: ___ Supervisorial District: _____ Fax: ( ) _____

Impact Unit Representative: _____ **Date:** _____

TO BE COMPLETED BY FSP AGENCY

(Referral and Authorization Form must be submitted to **Impact Unit** for your Service Area through SRTS)

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL** **Intake Date :** _____

☐ **AGENCY DECLINES TO ENROLL, BUT THE INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP** (Explain reason for decision and plan for linkage to other services)

_____

_____

FSP Agency Representative: _____ **Date:** _____

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES AND NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

FSP Agency Representative: _____ **Date:** _____

TO BE COMPLETED BY COUNTYWIDE ADMIN.

☐ **NOT AUTHORIZED FOR ENROLLMENT**

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

Previous FSP/ IFCCS / Wraparound Enrollment Within 365 Days: ☐ YES ☐ NO

Previous Agency Name: _____

Program: ☐ FSP ☐ IFCCS ☐ Wraparound

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

Countywide Programs Representative: _____ **Date:** _____

↓↓TO BE COMPLETED BY SERVICE AREA IMPACT UNIT↓↓

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ by _____

Date **Impact Unit Representative**

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.

IFCCS DISPOSITION

Individual's Name: _____

IS/IBHIS #: _____

TO BE COMPLETED BY CSOC ADMINISTRATION

Date Received: _____

Reviewed By: _____

☐ **ASSIGNED**

Agency Assigned To: _____ Date: _____

Previous FSP/ IFCCS / Wraparound Enrollment Within 365 Days: ☐ YES ☐ NO

Previous Agency Name: _____

Program: ☐ FSP ☐ IFCCS ☐ Wraparound

☐ **NOT ASSIGNED**

Reason:

Linkage:

Provider #: _____

Agency Address: _____ City: _____ Zip Code: _____

Contact Person: _____ Phone: _____

Service Area: _____ Supervisorial District: _____ Fax: _____

Date of First Face-to-Face Contact: _____

Please check one of the following:

☐ **Has Been Enrolled in IFCCS** **Intake Date:** _____

☐ **Not Enrolled in IFCCS (Please select one of the following):**

☐ **Does Not Agree to IFCCS**

(Explain reason for decision and plan for linkage to other services)

☐ **Deemed Ineligible for IFCCS**

(Explain reason for decision and plan for linkage to other services)

☐ **Other**

(Please specify):

Agency Representative: _____ **Date**: _____