Mental Health Assessment for General Relief

Date:
Case Name:
Case Number:
District Name:
District Address:
Worker Name:
Worker File Number:
Worker Phone Number:

DEAR HEALTH CARE PROVIDER:

The above named person has applied for General Relief (GR) Program assistance with the County of Los Angeles, Department of Public Social Services. The GR program requires that all employable individuals participate in work, training, or educational activities for 20 hours per week and make "satisfactory progress" in their activities; however if a person has a physical or mental disability that renders them unable to fulfill these work related requirements, they may be exempted from this requirement. We request information to help determine if the patient's mental health condition will affect his/her ability to successfully complete 20 hours per week of work and/or work-related training requirements.

A signed "AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION" should be submitted with this form. Your prompt return of this information will ensure timely processing of the application/re-certification for assistance.

Thank you for your assistance.

Section 1 must be completed by the patient/client or the provider *(or his/her authorized representative)*.

Sections 2 and 3 are to be completed by a licensed mental health professional (*or his/her designee)*.

CLINIC STAMP

SECTION 1. PATIENT/CLIENT INFORMATION

NAME OF PATIENT/CLIENT *(LAST, FIRST, MIDDLE)*	SEX *(CIRCLE)* M F	BIRTH DATE	SOCIAL SECURITY NUMBER (last 4 digits only) XXX - XX -

SECTION 2. STATEMENT OF PROVIDER

The information requested is needed to evaluate whether the person named above is able to participate in work or work related training program for the GR program due to his/her mental/behavioral impairment. Please answer the following questions:

1. Does the patient have any mental, developmental, and/or behavioral impairment that substantially limit one or more life activities of the patient and prevents him/her from engaging in work or a work related training program? ☐ **YES** ☐ **NO**

   If YES, complete the rest of this form as appropriate.
   If NO, complete the Provider Certification Section below.

2. Onset Date of Condition _____

3. Is the patient actively seeking treatment? ☐ **YES** ☐ **NO**

4. The condition is expected to last (check one):

   ☐ Less than one year (Please indicate the duration of impairment_____), or
   ☐ More than one year

5. Does the patient's condition potentially qualify him/her for Supplemental Security Income (SSI) benefits? ☐ **YES** ☐ **NO**

SECTION 3. PROVIDER CERTIFICATION

SIGNATURE OF PROVIDER OR PROVIDER'S AUTHORIZED REPRESENTATIVE	LICENSE NUMBER	DATE SIGNED
PRINT NAME AND TITLE/SPECIALTY		PHONE NUMBER ( )
STREET ADDRESS *(MAILING ADDRESS, IF DIFFERENT)*	CITY	STATE ZIP CODE

Mental Health Assessment for General Relief

Dear Health Care Provider,

The person named on the form applied for the General Relief (GR) Program benefits with the County of Los Angeles, Department of Public Social Services and need your assistance completing the Mental Health Assessment for GR, ABP 1676-3 form. The Department utilizes this form to have mental health professionals document the individual's mental health condition. Based on this information, we can better provide additional services to this person and assign him/her to an appropriate work-related activity.

The GR Program assists needy adults who are ineligible for State or Federal assistance. An average GR case consists of one person, living alone, with no income or resources. The maximum monthly GR grant is $221.

GR applicants are required to participate in work, training, or educational activities for 20 hours per week, which are offered by the GR Opportunities to Work (GROW) Program. These activities are geared to help individuals obtain or retain employment, unless the individual self discloses experiencing a mental health condition that prevents participation in this program. Individuals in GR must make "satisfactory progress" in their activities to remain eligible for GR benefits. However, if a person has a mental health impairment that renders them unable to participate in these activities, they may be exempted from this work requirement.

Please complete, sign, and give the individual the original of the completed attached mental health evaluation for our records. Your evaluation will be retained in the individual's records and it is confidential.

If you have any questions you may contact the Administrator at General Relief Special Projects and Supplemental Security Income Advocacy Section at Department of Public Social Services Administrative Headquarters at (562) 908-6732.

Thank you for your assistance.