

HSH/DMH/LAHSa REFERRAL FORM FOR INTERIM HOUSING

The information provided below will be used to determine program eligibility and the most appropriate housing resource.

REFERRING ENTITY INFORMATION

Date of Referral: _____ Name of Referring Entity: _____
 Referring Staff Name: _____ Referring Staff Title: _____
 Referring Staff Phone Number: _____ Referring Staff Email Address: _____
 Alternate Contact Name: _____ Alternate Contact Title: _____
 Alternate Contact Phone Number: _____ Alternate Contact Email Address: _____

Referring Entity Type:

- Private Hospital Private Non-DHS Urgent Care Jail/Custody Setting (Non-ODR) Skilled Nursing Facility
 CBEST Program Mental Health Outpatient Treatment Facility Substance Use Disorder Residential Treatment Facility
 Substance Use Disorder Outpatient Treatment Facility (including Withdrawal Management Program) CARE Court
 Street-Based Outreach Program, specify: LAHSa Outreach Team DMH Outreach Team HSH Outreach Team
 If Street-Based Outreach Program, select Outreach Team name.
- | | | |
|--|--|--|
| <input type="checkbox"/> SPA 1 - MHA LA | <input type="checkbox"/> SPA 4 - C3 Skid Row Team (Blue) | <input type="checkbox"/> SPA 5 - St. Joseph Center |
| <input type="checkbox"/> SPA 1 - LAFH | <input type="checkbox"/> SPA 4 - The People Concern | <input type="checkbox"/> SPA 6 - HOPICS |
| <input type="checkbox"/> SPA 2 - LAFH | <input type="checkbox"/> SPA 4 - The Center at Blessed Sacrament | <input type="checkbox"/> SPA 6 - SSG MLK Campus |
| <input type="checkbox"/> SPA 2 - SFVCMHC, Inc. | <input type="checkbox"/> SPA 4 - Homeless Health Care LA | <input type="checkbox"/> SPA 6 - SSG CD8 |
| <input type="checkbox"/> SPA 3 - USHS | <input type="checkbox"/> SPA 4 - Exodus Recovery NELA | <input type="checkbox"/> SPA 7 - PATH |
| <input type="checkbox"/> SPA 4 - C3 Skid Row Team (Red) | <input type="checkbox"/> SPA 4 - Exodus/LAC + USC Team | <input type="checkbox"/> SPA 8 - MHA LA |
| <input type="checkbox"/> SPA 4 - C3 Skid Row Team (Purple) | <input type="checkbox"/> SPA 5 - C3 Venice Team | <input type="checkbox"/> SPA 8 - Harbor UCLA Campus Team |
| <input type="checkbox"/> SPA 4 - C3 Skid Row Team (Yellow) | <input type="checkbox"/> SPA 5 - C3 Santa Monica Team | <input type="checkbox"/> PATH Metro Team |
| <input type="checkbox"/> Other, specify: _____ | | |
- HSH ICMS Provider and participant is not being served by one of the above entities.
 Victim Service Provider, specify: _____
 Other referring entity, specify: _____

PARTICIPANT INFORMATION

Participant Name (First, Middle, Last): _____ DOB: _____ Age: _____
 Social Security # (if known): _____ Medical Record #: _____
 *Required if Social Security # unknown:
 *Participant Maiden Name _____ *Place of Birth _____
 HMIS# (if known): _____ CHAMP ID # (if known): _____ IBHIS # (if known): _____
 CES Acuity Score: _____ CES Score is for a: Youth/Adult Family Matched to Housing Resource? Yes No

Participant Demographics

Race and Ethnicity: American Indian, Alaskan Native, Indigenous Black, African American, or African Asian or Asian American
(Select all that apply) Hispanic/Latina/e/o Middle Eastern or North African Native Hawaiian or Pacific Islander
 White Client doesn't know Client prefers not to answer Data not collected

Gender: Man (Boy if child) Woman (Girl if child) Transgender Non-Binary Questioning

Identity: Culturally Specific Identify (e.g., Two-Sprits) Different Identity, specify: _____
 Client doesn't know Client prefers not to answer Data not collected

Indicate the participant's gender bed preference:

- Male Female No Preference

Pronouns: She/Her He/Him They/Them Other: _____

Sexual Orientation: Asexual Pansexual Queer Straight/heterosexual
 Gay or Lesbian Bisexual Questioning Other _____

Have you served in the US Armed Forces? Yes No Client doesn't know Clients prefers not to answer Data not collected

Primary Language Spoken: _____ Limited English proficiency requiring translation services? Yes No

Participant Phone Number: _____ Participant Email Address: _____

Participant Name: _____

HMIS/CHAMP/IBHIS ID#: _____

PARTICIPANT INFORMATION

Participant Current Location:

- SPA 1 - Antelope Valley SPA 2 - San Fernando Valley SPA 3 - San Gabriel Valley SPA 4 - Metro LA (Non Skid Row)
- SPA 4 – Skid Row Only SPA 5 - West LA SPA 6 - South LA SPA 7 - South East LA SPA 8 - South Bay/Long Beach

Specify address including city and zip code or cross streets where participant typically resides (Information required for placement options): _____

Is the participant chronically homeless (Experienced homelessness for 365 consecutive days or longer, or experienced at least four episodes of homelessness in the last three years that total a year or longer)? Yes No

If no, length of Homelessness (Months) <2 2-3 4-6 7-9 10-11

How was chronic/length of homelessness verified? HMIS 3rd Party Certification Participant Self-Reported

Is the participant currently connected to an Office of Diversion and Re-entry (ODR) funded program?

Yes No If yes, specify the name of the program and provider: _____

Is the participant currently in law enforcement custody, due to the lack of housing, while awaiting an upcoming trial or court hearing?

Yes No If yes, specify the anticipated discharge date: _____

Did the participant exit an institution within the last 90 days? Yes No If yes, specify the discharge date: _____

Select type of Institution: Jail/Prison Hospital Emergency Room Substance Use Treatment Facility

Foster Care Detention Center Residential Care Facility

Is the participant conserved or does the participant have a conservatorship hearing pending? Yes No

If yes, type of conservatorship: LPS Probate

Other Considerations: AB109 Probation Convicted of Arson Registered Sex Offender Veteran N/A

Fleeing/attempting to flee: Domestic Violence Human Trafficking or Sex Trafficking Sexual Assault N/A

HOUSEHOLD INFORMATION

(Only complete if the participant is requesting to be housed with family)

Minor Children

- Name: _____ DOB: _____ Age: _____ Gender: M F Other Legal Custody: Yes No
- Name: _____ DOB: _____ Age: _____ Gender: M F Other Legal Custody: Yes No
- Name: _____ DOB: _____ Age: _____ Gender: M F Other Legal Custody: Yes No
- Name: _____ DOB: _____ Age: _____ Gender: M F Other Legal Custody: Yes No
- Name: _____ DOB: _____ Age: _____ Gender: M F Other Legal Custody: Yes No

(If there are more minor children to be housed with participants, provide the above-requested information in the "Additional Information" section below.)

Additional Adults in Household

- Name: _____ DOB: _____ Age: _____ Gender: M F Other Qualified Dependent*: Yes No
- Name: _____ DOB: _____ Age: _____ Gender: M F Other Qualified Dependent*: Yes No

*Qualified dependents are over age 18, incapable of employment due to mental/physical disability, and dependent upon the participant for financial support. (If there are more adult individuals to be housed with participants, provide the above-requested information in the "Additional Information" section below.)

Is the participant pregnant? Yes No If yes, how many weeks? _____

Are any other members of the household pregnant? Yes No If yes, what relationship to the participant? _____

Additional Information: _____

PRESENTING ISSUE(S)

Select all that apply to the participant.

- Medical: Mental Health: Recent Substance or Substance Use Cognitive Impairments:
- The participant does not have any of the above issues.

Participant Name: _____

HMIS/CHAMP/IBHIS ID#: _____

TUBERCULOSIS (TB) SCREENING

- 1. Has the participant had a cough recently that has lasted longer than 3 weeks? Yes No Don't Know
- 2. Has the participant recently lost weight without explanation during the past month? Yes No Don't Know
- 3. Has the participant had frequent night sweats during the past month, soaking their sheets or clothing? Yes No Don't Know
- 4. Has the participant coughed up blood in the past month? Yes No Don't Know
- 5. Has the participant been feeling much more tired than usual over the past month? Yes No Don't Know
- 6. Has the participant had fevers almost daily for more than one week? Yes No Don't Know

If the participant has a prolonged cough (> 3 weeks) AND answers yes to any other TB screening question, the participant must be promptly referred to a healthcare provider for an evaluation.

TB Test Performed: Yes No Date Completed: _____ Results: _____

Chest X-Ray Performed: Yes No Date Completed: _____ Results: _____

ADDITIONAL PARTICIPANT/HOUSEHOLD INFORMATION

Select all that apply to the participant.

- Needs assistance with Activities of Daily Living (i.e., bathing, dressing, transferring, toileting, eating) Has caregiver support
- Incontinent of bladder or bowel and independent with the use of incontinence supplies Needs caregiver support
- Respiratory issues requiring an oxygen tank Cannot transfer (e.g., from wheelchair to bed) Cannot climb stairs
- Independently uses walker/cane/crutches Independently uses a motorized wheelchair Significant visual impairment
- Independently uses a manual wheelchair Significant auditory impairment Needs bottom bunk
- Other additional information, specify: _____

Does any of the above apply to other household members being placed with the head of the household? If yes, specify: _____

Does the participant/household have any animal(s) that will accompany them into Interim Housing?

Yes No If yes, complete questions 1-3 below.

1. Is the animal a service animal? Yes No If yes, # of animals: _____ Type(s): _____ Weight: _____

2. Is the animal an emotional support animal? Yes No If yes, # of animals: _____ Type(s): _____ Weight: _____

3. Is the animal a pet? Yes No If yes, # of animals: _____ Type(s): _____ Weight: _____

CURRENT SLEEPING/LIVING ARRANGEMENT

Select the category that best describes the participant's current sleeping/living arrangement.

- Sleeping in a place not meant for human habitation, specify: Street Park Campground Vehicle Other, specify: _____
- Shelter/Interim Housing (Shelter Name: _____)
Shelter Funder: LAHSA DMH DHS VA Other Unknown
- Hotel/Motel fully or partially subsidized by a public or non-profit agency
- Exiting an institution (Jail/Prison, Foster Care, Detention Center, Residential Care Facility, or Substance Use Treatment Facility) where the participant has resided for:
 - 90 days or less
 - For more than 90 days AND participant resided in Shelter/Interim Housing, or a place not meant for human habitation before entering the institution
- Staying temporarily with family/friends
- Recent eviction/relinquishing unit to prevent eviction Date of eviction/unit relinquished: _____
- Other sleeping/living arrangements, specify: _____

Participant Name: _____

HMIS/CHAMP/IBHIS ID#: _____

INTERIM HOUSING PLACEMENT LOCATION

1. Is the participant willing to reside in a congregate living environment? Yes No (Most Interim Housing sites are congregate living environments.)
2. Is the participant willing to reside in the Skid Row area? Yes No
3. Is the participant willing to sleep on a top bunk of a bunk bed? Yes No
4. Is there any SPA(s) where the participant would prefer to live in Interim Housing? Select all that apply.
- SPA 1 - Antelope Valley SPA 2 - San Fernando Valley SPA 3 - San Gabriel Valley SPA 4 - Metro LA
- SPA 5 - West LA SPA 6 - South LA SPA 7 - South East LA SPA 8 - South Bay
5. Is there any city/cities where the participant would prefer to live in Interim Housing? Yes No If yes, specify: _____
6. Does the participant have an Interim Housing provider(s) preference? Yes No If yes, specify: _____
7. Is the participant willing to go to an alternate provider? Yes No
8. Is there any SPA(s) where the participant **CAN NOT** live in Interim Housing? Select all that apply.
- SPA 1 - Antelope Valley SPA 2 - San Fernando Valley SPA 3 - San Gabriel Valley SPA 4 - Metro LA
- SPA 5 - West LA SPA 6 - South LA SPA 7 - South East LA SPA 8 - South Bay
9. Is there any city/cities where the participant **CAN NOT** live in Interim Housing?
- Yes No If yes, specify: _____

Additional Required Document Acknowledgement

For referrals submitted to DMH or HSH, check that the below-required documents are included with the referral submission. This is not applicable to referrals submitted to LAHSA.

DMH

- Los Angeles County Department of Mental Health Authorization for Use or Disclosure of Protected Health Information
- Supplemental Form (Attachment A) for Interim Housing for participants that meet any of the Participant Review criteria on page 1

HSH

- DHS Notice Of Privacy Practices Acknowledgment Form
- Supplemental Form (Attachment A) for Interim Housing
- Authorization for the Use and Disclosure of Health and Social Service Information (Universal Consent Form)