



**ICMS Information**

Housing Project Name		Agency	
Project Address		Unit/Apt #	Zip Code
ICMS Contact Person Name		ICMS Contact Person Title	
ICMS Contact Person Email		ICMS Contact Phone #	Ext.

**Individual Information**

Last Name		First Name		Phone	DOB
Social Security #	IBHIS #	HMIS #	CES Acuity Score	Preferred Language	
Gender	Veteran	Ethnicity		Race	
Has the individual been screened or assessed for a mental health diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please explain: _____					
Does the individual have emergent medication needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined If yes, please explain: _____					
Is client aware that an HSSP referral has been made on their behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____					
Is ICMS available for Collaborative Outreach? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Language needs? <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Presenting Issues**

Is this a priority referral:  Yes  No If yes, please explain: \_\_\_\_\_

Presenting Problems:  Yes  No If yes, please explain: \_\_\_\_\_

Safety Issues:  Yes  No If yes, please explain: \_\_\_\_\_

5x5 Score \_\_\_\_\_ (please attach a copy)

**Check all that apply to individual:**

- Danger to self/Suicidal/Self Harm:  Current ideation/thoughts  Past ideation/thoughts  Past attempts
- Aggression and/or danger to others:  Threats  Thoughts/ideation only  Behavior and/or assaultive history  Tarasoff Notifications (current or past)
- Justice system involved:  Yes  No If yes, please explain (current or past): \_\_\_\_\_
- Inappropriate sexual conduct:  Thoughts/ideation only  Behavior
- Fire setting:  Thoughts/ideation only  Behavior
- Psychiatric hospitalization: (most recent date) \_\_\_\_\_
- Grave Disability  Psychosis  Alcohol, Cannabis, and/or Substance Abuse  Other Symptoms: \_\_\_\_\_
- Victim of domestic violence/interpersonal violence

Provide details for any checked items; describe candidate's immediate risk, safety concerns, and most concerning behavior that occurred, including danger to self and others:

**Income Verification (Select All that Apply)**

**INSURANCE:**  Medi-Cal  Medicare  None  Private: \_\_\_\_\_

**BENEFITS:**  SSI  SDI  SSDI  GR  Social Security  VA  CalWORKS  Wages/Salary

Unemployment  Other (specify): \_\_\_\_\_  None

**Household Size (Attach additional page if necessary)**

1 person  2 people  3 people  4 people  Other: \_\_\_\_\_

If more than one person is checked above, complete the following:

Name	Name	Name	Name
Relationship	Relationship	Relationship	Relationship
Date of Birth	Date of Birth	Date of Birth	Date of Birth
Age	Age	Age	Age

**HSSP CLINICIAN ONLY SECTION**

**Disposition of Referral**

Outreach and Engagement Date: \_\_\_\_\_  Enrollment Date: \_\_\_\_\_

Was ICMS present for collaborative outreach with this client?  Yes  No ICMS Contact Person Name: \_\_\_\_\_

Will provide continue outreach and enrollment date to follow (30-day follow-up): Date: \_\_\_\_\_

Additional Motivational Interview needed to address ambivalence. Client decline services at this time. Date: \_\_\_\_\_

Unable to reach client, will coordinate follow-up with ICMS\* Date: \_\_\_\_\_

\*Attempts and efforts made to reach client (Dates and steps taken. Example: knocked on clients door, called, etc.):

\_\_\_\_\_  
HSSP Clinician Contact Name

\_\_\_\_\_  
HSSP Clinician Contact Person Title

\_\_\_\_\_  
HSSP Clinician Contact Person Email

\_\_\_\_\_  
HSSP Clinician Contact Phone #

\_\_\_\_\_  
Ext.

**If the engagement box above is checked.  
Please resubmit this completed form with the added enrollment date to the email address below.**

**EMAIL COMPLETED FORM TO: [enrollHSSP@dmh.lacounty.gov](mailto:enrollHSSP@dmh.lacounty.gov)**