

Prevent Homelessness Promote Health (PH²) – DHS/DMH Collaboration Physical/Mental Health Assistance Referral

REFERRING AGENCY CONTACT INFORMATION

Agency:		Date:	
Staff Name:	Email:	Phone:	
Supervisor Name:	Email:	Phone:	

CLIENT INFORMATION

Reason for referral: Physical Health (Submit referral to: HSHmedicalcasemanagement@HSH.lacounty.gov)
 Mental Health (Submit referral to: pshsquared@dmh.lacounty.gov)

Client Name:	D.O.B.:	SSN:	Gender:
Ethnicity:	Primary Language:	Orchid ID:	Champ ID:

Type of housing: Board and Care Market Rate Project Based Scattered Site

Length of housing: _____

Client Address:	Client Phone:	Service Area:
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Other client information: _____

PHYSICAL HEALTH INFORMATION

Client Health Insurance:	ID#:	Expiration Date:	
Client PCP:	Location:	Clinic Phone #:	Care Manager Ph. #:
Other Provider:	Location:	Clinic Phone #:	Specialty:

How many times has the client accessed the ER or inpatient care in the last 12 months (if known)? _____

Date:	Facility:	Date:	Facility:
_____	_____	_____	_____
Date:	Facility:	Date:	Facility:
_____	_____	_____	_____
Date:	Facility:	Date:	Facility:
_____	_____	_____	_____

Is the client making regular visits to a primary care physician? Yes No

If **NO**, why is the client not accessing primary care services? _____

Is the client currently prescribed any medications? Yes No

List all medications: _____

Is the client compliant with the prescribed medication plan? Yes No

If **NO**, is the client's health worse due to poor medication adherence? Yes No

Recent incarceration/transition out of jail? Yes No

MENTAL HEALTH INFORMATION

Is the client currently receiving mental health services? Yes No If Yes, IBHIS #: _____

Type of housing voucher: Age 16-25 65 years or older Family Unit Single Adult Veteran

Other: _____

Check all concerns/tenant violations and list dates:

Aggressive/Violent Behavior Destruction of Property Failure to Pay Fire Safety/Health Hazard

Hoarding Infestation Legal Relationship Conflicts Substance Abuse

Other: _____

Is client at-risk of returning to homelessness? Yes No

Is eviction expected w/in the next 30 days? Yes No

Have there been or are there currently any safety issues? Yes No If **YES**, describe below:

SERVICES NEEDED

Assessment of higher level of care/In-Home Caregiving (IHCG)/In-Home Supportive Services (IHSS)

Medication review/adherence support (short-term)

Physical health assessment and short-term support/linkage

Substance Use Disorder (SUD) assessment and short-term support/linkage

Mental health assessment and short-term support/linkage

Functional assessment and short-term support/linkage

Assistance with housing accommodations

Other (please see attached sheet for details)

NOTE: Permanent Supportive Housing (PSH) RNs cannot do blood draws or 5150 holds.

Intensive Case Management Services (ICMS) is responsible for doing routine accompaniments and transitions of care as well as ensuring that clients have active health insurance and are empaneled to primary care. ICMS is also responsible for housing and social services support (food, transportation, etc.), M-F only.

ADDITIONAL INFORMATION RELEVANT TO THIS REQUEST

Medical/mental health diagnosis if known: _____

****If eligible for assistance, HFH Nursing staff OR DMH will contact agency staff. HFH OR DMH Program Manager will inform agency staff if the participant is NOT eligible for assistance.**

Submit **mental health** referral to: [pksquared@dmh.lacounty.gov](mailto:phsquared@dmh.lacounty.gov)

AND physical health referral to: hshmedicalcasemanagement@HSH.lacounty.gov.