LA COUNTY Homeless Services & Housing

# REQUEST FOR ENRICHED RESIDENTIAL CARE ASSESSMENT

Date: _____

This form is used by HSH facilities and other HSH specialized programs, to request an assessment from the ERC Care Team of an individual who is likely appropriate for placement at a licensed residential care facility. Completing this form does not guarantee that the applicant will be approved for the ERC program. HSH ERC staff will follow-up with the referring party to inform them of the results ERC assessment and if the next step is necessitated.

**How do you request an ERC Assessment?**

1. Complete Housing for Health ERC Application in the CHAMP system.
2. Upload copies of the client's signed Universal Consent and Notice of Privacy Practices forms.
3. Complete this form, Request for ERC Assessment, and upload all three pages in the CHAMP system.
4. Review the list on page 3 of all required and supplemental documents to be submitted with this request.
5. Upload all requested forms and documents into the CHAMP system or, if you do not have access to the CHAMP system, email the forms to **ERC-Referrals@hsh.lacounty.gov**

| Referring Agency Name: | Staff Name/Title: | | |
|---|---|---|---|
| Office Phone #: | Cell #: | Staff Email: | |
| Client's First Name: | Client's Middle Name: | Client's Last Name: | CHAMP ID: |

| Gender: | Date of Birth: | Age: | Residency Status: | Preferred Language (If other than English): |
|---|---|---|---|---|
| ☐ Male ☐ Female<br>☐ Transgender F-M<br>☐ Transgender M-F<br>☐ Not specified/option not available | | | ☐ US Citizen<br>☐ Legal Resident<br>☐ Other | |

Client's current location/address:

_____

_____

Health Insurance (Check all that apply):

☐ Medi-cal ☐ Medicare ☐ Private ☐ None

☐ Unknown Managed Care Provider

CIN#/Subscriber ID:_____

Primary Care Provider: _____

Mental Health Provider: _____

Client's Income (check all that apply):

☐ No Income ☐ Food Stamps/Cal Fresh

☐ General Relief ☐ Unemployment

☐ SSI ☐ Employment

☐ SSDI ☐ CAPI

☐ VA Benefits ☐ CalWORKS

☐ Pending – Date of Application: _____

☐ Other: _____

_____

Monthly income amount: _____

Does the client have a next of kin? ☐ Yes ☐ No

If Yes, provide name(s), relationship(s) to client, and contact information: _____

_____

_____

Does the client have an emergency contact(s)? ☐ Yes ☐ No

If Yes, provide name(s), relationship(s) to client, and contact information: _____

_____

_____



HSH Office Use:

Date received: _____ Date Sent for Assessment: _____ ☐ Approved ☐ Denied Initials: _____

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**Instructions**

**Please answer the following questions by marking the appropriate box and providing all relevant information. Please upload the completed form into CHAMP or where you do not have access, email to ERC-Referrals@hsh.lacounty.gov**

**Check all that apply:**

1. Is the client: ☐ Legally Blind ☐ Speech Impaired ☐ Cognitively Impaired ☐ Hearing Impaired
2. Does the client use: ☐ Assistive Communication ☐ Sign Language ☐ Hospital Bed ☐ Cane or Walker ☐ Wheelchair
   If client uses a wheelchair, are they able to transfer in/out of the wheelchair: ☐ Independently ☐ Needs Assistance
3. Is the client able to transfer to/from a commode: ☐ Independently ☐ With Proper Equipment ☐ Needs Assistance
4. Does the client need assistance with medication monitoring or dispensing: ☐ Yes ☐ No
5. Is the client incontinent of: ☐ N/A ☐ Bowel ☐ Bladder If indicated: can the client self-care: ☐ Yes ☐ No
6. Does the client use diapers: ☐ Yes ☐ No If yes, can they change themselves independently: ☐ Yes ☐ No

**Please Describe Limitations/Concerns Related to Any Impairments Identified Above:**

_____
_____
_____
_____

**Mental Health:**

7. Does the client have aggressive behaviors: ☐ Yes ☐ No If yes, please describe: _____
8. Does the client have violent tendencies? ☐ Yes ☐ No If yes, please describe: _____
9. Does the client have a mental health diagnosis? ☐ Yes ☐ No If yes: what is the diagnosis: _____

   If yes to #9, is the condition stable (well managed): ☐ Yes ☐ No
10. Is the client compliant with taking medications and following through with appointments and other care plans:
    ☐ Yes ☐ No

**Please Describe Limitations/Concerns Related to Any Impairments Identified Above:**

_____
_____
_____

**Cognitive Functioning:**

11. Is the client-oriented X's 4? (person, place, time, situation): ☐ Yes ☐ No
    If no, please describe: _____
12. Has client been diagnosed with: ☐ Cognitive impairment ☐ Dementia ☐ Developmental disability ☐ TBI

**Describe cognitive impairment or other neurocognitive disorder:**

_____
_____
_____
_____

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13. Does client have a legal surrogate decision maker: ☐ DPOA ☐ LPS Conservator ☐ Probate Conservator ☐ Other

    If yes, include: Name:_____ Agency:_____ Contact:_____

14. Does client have a representative payee: ☐ Yes ☐ No

    If yes, include: Name:_____ Agency:_____ Contact:_____

15. Does client have other court ordered treatment or decision makers that is current, or pending (i.e. temporary conservatorship for LPS, probate, or Riese hearings): ☐ Yes ☐ No ☐ Unknown

    If yes, explain: _____

16. Is the client capable of understanding instructions & consents for health treatment plans: ☐ Yes ☐ No

*If clients lacks decision making capacity and has no legal surrogate decision maker, the attending physician must complete a formal capacity declaration form (GC335 and GC335a) and submit/upload documents with ERC request. Refer client to Public Guardian's (PG) Office for conservatorship.*

**Date of Referral to the Public Guardian's (PG) Office:** _____

What steps, if any, have you already taken to find placement for this client:

_____
_____
_____
_____
_____

Other relevant details, barriers or issues regarding this client's housing needs:

_____
_____
_____
_____
_____

**Please upload the following required documents in the CHAMP System.**

Required:

☐ Request for ERC Assessment
☐ Universal Consent & Notice of Privacy Practices Forms
☐ Pre-placement Appraisal Information Form LIC603
☐ Physician's Report LIC60A with TB Test Results
☐ Existing History & Physical, and Medication List
☐ ERC Payment Responsibilities Form

If Applicable:

☐ DPOA
☐ Advanced Directives or Advanced Care Planning Sheet
☐ POLST
☐ MOCA or MMSE Form
☐ GC335 and GC335a
☐ Award Letter / Income Verification Form
☐ Medical Insurance Verification