COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OLDER ADULT (AGES 60+) FULL SERVICE PARTNERSHIP REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

DATE: _____ DMH IS#: _____

LAST NAME: _____ FIRST NAME: _____ PREFERRED LANGUAGE: _____

DOB: _____ RACE/ ETHNICITY _____ GENDER: ☐ M ☐ F SSN: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PHONE ( ) _____ CURRENT LIVING SITUATION: _____

INSURANCE: ☐ MEDI-CAL ☐ MEDICARE ☐ VA ☐ PRIVATE ☐ NONE

PRIMARY CONTACT: _____ RELATIONSHIP: _____

PREFERRED LANGUAGE: _____ PHONE: ( ) _____

CONSERVATOR ? ☐ YES ☐ NO WHOM?: _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: ( ) _____ Fax: ( ) _____ E-mail: _____

Is Individual currently receiving services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ APS ☐ Probation ☐ DMH ☐ Regional Center

If Individual was referred to any other programs, please identify: _____

_____

_____

FOCAL POPULATION

Referral Name: _____

CHECK APPROPRIATE **REASON(S) FOR REFERRAL** OF AN OLDER ADULT WITH SERIOUS MENTAL ILLNESS:

1. ☐ Homelessness (# Number of Days Homeless over last 12 months_____)
2. ☐ Incarceration (# of Incarcerated days over last 12 Months _____)
3. ☐ Hospitalization (# of acute psychiatric inpatient days _____)
4. ☐ At imminent risk of homelessness (e.g. at risk of eviction due to code violations)
5. ☐ Risk of going to jail (e.g. multiple interactions with law enforcement over 6 months or more)
6. ☐ Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home
7. ☐ Being released from SNF/ Nursing Home (What facility _____)
8. ☐ Presence of a Co-occurring disorder:
   - ☐ Substance Abuse
   - ☐ Developmental Disorder
   - ☐ Medical Disorder
   - ☐ Cognitive Disorder
9. ☐ Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated (e.g. APS- referred clients)
10. ☐ Serious risk of suicide (not imminent)
11. ☐ Current enrollment in an ACT/AB2034 program and is aging up in the system (ACT/AB2034 program _____)

LEVEL OF SERVICE

Referral Name: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **DSM-IV-TR Diagnosis**: _____ **Dual Diagnosis** (X Code): _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Tarasoff Notifications (past or current)
- ☐ Suicidal Ideation/Attempts

Other _____

Provide Detail for Any Checked Items: _____

_____

_____

_____

_____

_____

Fax completed Referral and Authorization Form to **Impact Unit Coordinator**:

Matthew Wells **(213) 351-2493**

DISPOSITION

Referral Name: _____

↓↓**TO BE COMPLETED BY SERVICE AREA IMPACT UNIT**↓↓

DATE RECEIVED: _____

☐ **NOT PRE-AUTHORIZED FOR ENROLLMENT** (Explain reason for decision and plan for linkage to other services):

_____

_____

☐ **PRE-AUTHORIZED FOR ENROLLMENT:**

Name of FSP Agency: _____ Provider # _____

FSP Agency Address: _____ City: _____ ZIP Code _____

Contact Person: _____ Phone: ( ) _____

Service Area: _____ Supervisorial District: _____ Fax: ( ) _____

Impact Unit Representative: _____ **Date:** _____

↓↓**TO BE COMPLETED BY FSP AGENCY**↓↓

(**Fax** completed Referral and Authorization Form to **Impact Unit** for your Service Area)

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND INDIVIDUAL DOES NOT AGREE TO OR IS DETERMINED INAPPROPRIATE FOR FSP SERVICES** (Explain why and indicate plan for linkage to other services):

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND DECLINES ENROLLMENT** (Explain reason for decision and indicate status of client): _____

_____

_____

☐ **FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND REQUESTS ENROLLMENT***

FSP Agency Representative: _____ **Date:** _____

***IMPACT UNIT:** **Fax** completed Referral and Authorization Form to Children's MHSA **Countywide Programs Administration** at **(213) 351-2493**. If you have any questions, please contact Matthew Wells at (213) 351-5344.

↓↓**TO BE COMPLETED BY COUNTYWIDE PROGRAMS ADMINISTRATION**↓↓

☐ **NOT AUTHORIZED FOR ENROLLMENT** (Explain reason for decision): _____

_____

_____

☐ **AUTHORIZED FOR ENROLLMENT**

Countywide Programs Representative: _____ **Date:** _____

REFERRAL SOURCE NOTIFIED OF DISPOSITION on _____ by _____

Date — Impact Unit Representative