COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHILDREN'S (AGES 0-15)
FULL SERVICE PARTNERSHIP
REFERRAL AND AUTHORIZATION FORM

REFERRAL INFORMATION

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DMH IS#: _____

DATE: _____ **SSN:** _____

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

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY** _____ **GENDER:** ☐ **M** ☐ **F** [**UNKNOWN**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **HEALTHY FAMILIES** ☐ **HEALTHY KIDS** ☐ **PRIVATE** ☐ **NONE**

PRIMARY CONTACT: _____ **RELATIONSHIP:** _____

PREFERRED LANGUAGE: _____ **PHONE:** ( ) _____

CONSERVATOR ? ☐ **YES** ☐ **NO** **NAME:** _____ **PHONE:** ( ) _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

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

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

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

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

☐ Client is aware client has been referred to the FSP Program

FOCAL POPULATION

Individual's Name: _____

DMH IS#: _____

CHECK APPROPRIATE **REASON(S) FOR REFERRAL** OF A CHILD WITH SERIOUS EMOTIONAL DISTURBANCE (SED):*

1. Zero to five-year-old (0-5) who:

   ☐ is at high risk of expulsion from pre-school

   ☐ is involved with or at high risk of being detained by Department of Children and Family Services (DCFS)

   ☐ has a parent/caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorders

2. Child/youth who:

   ☐ has been removed or is at risk of removal from their home by DCFS

   ☐ is in transition to a less restrictive placement

3. Child/youth who is experiencing the following at school:

   ☐ suspension or expulsion

   ☐ violent behaviors

   ☐ drug possession or use

   ☐ suicidal and/or homicidal ideation

4. Child/youth who:

   ☐ is involved with Probation, is on psychotropic medication, and is transitioning back into a less structured home/community setting

Provide Detail for Any Checked Items:

_____

_____

DCFS Case: ☐ **ER Case** ☐ **Voluntary Case** ☐ **Open Case**

CSW Name: _____ **PHONE:** ( ) _____

Supervisor's Name: _____ **PHONE:** ( ) _____

Status:

_____

_____

*"Seriously emotionally disturbed" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. [California Welfare and Institutions Code Section 5600.3]

LEVEL OF SERVICE

Individual's Name: _____

DMH IS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ FCCS ☐ Outpatient ☐ PEI ☐ Other:
- ☐ 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
- ☐ Psychiatric Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)
- ☐ Other _____

Provide Detail for Any Checked Items:

_____

_____

_____

_____

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

SA 1: Salem Redding	(661) 537-2937	SA 4: Suyapa Umanzor	(323) 913-9175	SA 8: April Hagerty	(562) 256-1603
SA 2: Aleks Dozortzev	(818) 347-8738	SA 5: K. Chantraprabhavej	(310) 313-0813		
Colin (Fang) Xie		SA 6: Debresha McDaniel	(323) 290-3239		
SA 3: Victor Sanchez	(626) 455-4608	SA 7: Lori Prince	(213) 384-0729		

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DISPOSITION

Individual's Name: _____

DMH IS#: _____

DATE RECEIVED: _____

TO BE COMPLETED BY SERVICE AREA IMPACT UNIT

☐ **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:** _____

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

TO BE COMPLETED BY FSP AGENCY

FSP AGENCY HAS COMPLETED OUTREACH & ENGAGEMENT AND (Check only one box below):

FIRST FACE TO FACE CONTACT DATE: _____

☐ **REQUESTS AUTHORIZATION TO ENROLL**

☐ **AGENCY DECLINES TO ENROLL, BUT INDIVIDUAL IS ELIGIBLE FOR FSP** (Must complete FSP Appeal Form)

☐ **INDIVIDUAL DOES NOT AGREE TO SERVICES** (Explain reason for decision and plan for linkage to other services)

☐ **IS DEEMED INELIGIBLE FOR FSP SERVICES** (Explain reason for decision and plan for linkage to other services)

_____

_____

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

☐ **RECEIVED FINAL AUTHORIZATION, BUT INDIVIDUAL NEVER ENROLLED AND/OR NOW DOES NOT AGREE TO SERVICES *AND* NO FSP UNITS OF SERVICE WERE EVER BILLED** (Explain reason for decision and plan for linkage to other services) _____

_____

_____

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

TO BE COMPLETED BY COUNTYWIDE ADMIN.

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

☐ **AUTHORIZED FOR ENROLLMENT**

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

PREVIOUS FSP ENROLLMENT WITHIN 365 DAYS ☐ **YES** ☐ **NO** **AGENCY** _____

☐ **AUTHORIZED REFERRAL INACTIVE. INDIVIDUAL NEVER ENROLLED AND NO UNITS OF SERVICE BILLED**

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

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

REFERRAL SOURCE NOTIFIED OF DISPOSITION on: _____ (Date) by _____ (Impact Unit Representative)