

Los Angeles County Department of Mental Health
Homeless Full Service Partnership (FSP) Program Referral
(Securely email to HomelessFSP@dmh.lacounty.gov)



Request Date: _____

REFERRAL SOURCE

Agency/Program: _____ Contact Person: _____
Contact Person Title: _____ Service Planning Area: _____
Email: _____ Phone Number: _____
Alternate _____ Phone Number: _____
Contact: _____ Phone Number: _____

INDIVIDUAL'S INFORMATION

Last Name: _____ First Name: _____
Social Security Number: _____ Date of Birth: _____
Phone Number: _____ Preferred Language: _____
Gender: ☐ M ☐ F ☐ Trans Man ☐ Trans Woman ☐ Other Gender Identity, Specify: _____
City where Individual is Currently Located: _____ IBHIS Number If Known: _____
Insurance: ☐ Medi-Cal ☐ Medicare ☐ None ☐ Other, Specify: _____
Ethnicity: ☐ White ☐ Latino ☐ African American ☐ Asian ☐ American Indian ☐ Other, Specify: _____
Individual on: ☐ Probation ☐ AB 109 Probation ☐ Parole ☐ Non-Revocable Parole ☐ N/A
(Non-Revocable Parole refers to an individual who is not required to report to a parole agent)

Has the Individual Been Screened by a Clinician for a Severe Mental Illness? ☐ Yes ☐ No

If yes, Name of Clinician: _____ Email: _____

Does the Individual have Emergent Medication Needs? ☐ Yes ☐ No ☐ Undetermined (Explain): _____

Does the Individual have Any of the Following Medical Conditions? Check All that Apply:

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C/Liver Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Other, Specify: _____ | |

HMIS Number: _____ Coordinated Entry System (CES) Assessment Acuity Score (0-17): _____

Date CES Assessment Entered into HMIS: _____

DISPOSITION

(COMPLETED BY HOMELESS FSP PROGRAM ADMINISTRATION)

☐ Individual Meets Program Criteria - Referred To: _____

Contact Person : _____ Email: _____
Phone Number: _____ Referral Date: _____
Service Planning Area: _____ Provider Number: _____

☐ Homeless FSP Provider(s) at Capacity

☐ Individual Does Not Meet Program Criteria: _____

This confidential information is provided to you in accordance 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 the prior written authorization of the patient/authorized representative to whom it pertains unless otherwise permitted by law.