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 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:

☐ Diabetes ☐ Hepatitis C/Liver Disease ☐ HIV/AIDS
☐ Heart Disease ☐ Lung Disease ☐ Cancer
☐ Renal Disease ☐ 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: _____

Revised October 4, 2018