



# LAHSA/DHS/DMH REFERRAL FORM FOR BRIDGE/INTERIM HOUSING/INTERIM HOUSING PROGRAM

REFERRING PROGRAM UNIT/TYPE:

Date of Referral: \_\_\_\_\_

Date Referral Received: \_\_\_\_\_

Referring Program/Agency Name:	Referring Program Contact Name/Title:	Main Phone/Mobile #:	Email Address:
Alternate Referring Contact Name/Title:	Alternate Contact Main Phone/Mobile #:	Alternate Contact Email Address:	

**Referring Facility\*: Please choose ONE OPTION that best describes your facility/agency/program.**

*If you are unsure which option is most appropriate and your supervisor is not sure, please contact Housing or Health's Access, Referral, and Engagement Unit at [InterimHousing@dhs.lacounty.gov](mailto:InterimHousing@dhs.lacounty.gov) or at (213) 833-5370 for more information.*

- Private Hospital     Private Non-DHS Urgent Care     Jail/Custody Setting (Non-ODR)     Mental Health Outpatient Treatment Facility
- Mental Health Outpatient Treatment     Residential Substance Use Disorder Treatment Facility
- Substance Use Disorder Outpatient Treatment (including Withdraw Management Program)     CBEST     Foster Care System
- Street-Based Outreach Worker: Please select your SPA/Team information from the table below.
- Other, please describe: \_\_\_\_\_
- OR Referring agency is a DHS ICMS provider AND this client does NOT fit into one of the above categories.

\* Please Note: If you are a Los Angeles County DHS (LAC DHS) hospital, facility, or DHS ICMS or ODR provider you should NOT make referrals using this application. Please use the full, online CHAMP application to make a referral to DHS interim housing.

**Street-Based Outreach SPA/Team Selection:**     LAHSA Outreach Team     DMH Outreach Team

DHS Outreach Teams (Please select your SPA/Team from the list below):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> SPA 1 - MHA LA<br><input type="checkbox"/> SPA 1 - LAFH<br><input type="checkbox"/> SPA 2 - LAFH<br><input type="checkbox"/> SPA 2 - SFVCMC<br><input type="checkbox"/> SPA 3 - USHS<br><input type="checkbox"/> SPA 4 - C3 Skid Row Team (Red)<br><input type="checkbox"/> SPA 4 - C3 Skid Row Team (Purple)<br><input type="checkbox"/> SPA 4 - C3 Skid Row Team (Yellow) | <input type="checkbox"/> SPA 4 - C3 Skid Row Team (Blue)<br><input type="checkbox"/> SPA 4 - The People Concern<br><input type="checkbox"/> SPA 4 - The Center at Blessed Sacrament<br><input type="checkbox"/> SPA 4 - Homeless Health Care LA<br><input type="checkbox"/> SPA 4 - Exodus Recovery NELA<br><input type="checkbox"/> SPA 4 - Exodus/LAC + USC Team<br><input type="checkbox"/> SPA 5 - C3 Venice Team<br><input type="checkbox"/> SPA 5 - St. Joseph's Center | <input type="checkbox"/> SPA 5 - PATH Manchester Square Team<br><input type="checkbox"/> SPA 6 - HOPICS<br><input type="checkbox"/> SPA 6 - SSG MLK Campus<br><input type="checkbox"/> SPA 6 - SSG CD8<br><input type="checkbox"/> SPA 7 - PATH<br><input type="checkbox"/> SPA 8 - MHA LA<br><input type="checkbox"/> SPA 8 - Harbor UCLA Campus Team<br><input type="checkbox"/> PATH Metro Redline Team |
|--|---|--|

Other: \_\_\_\_\_

**Client Information:**

Client First Name:	Middle Name:	Last Name:	Mobile #/Email Address:	CHAMP ID # (if known):
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Man <input type="checkbox"/> Trans Woman <input type="checkbox"/> Other: _____	DOB:	Age:	Primary Language:	HMIS # (if known): CES Information (if known): Priority Score: _____ Acuity Score: _____ Matched to Housing? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Homeless Status**

- HUD Category 1: Literally homeless  
(Sleeping in a place not meant for human habitation, emergency shelter, transitional housing, residing in a hotel/motel paid for by a non-profit/charitable organization, or exiting an institution (Jail or Prison, Foster Care, Medical or Substance Abuse Treatment facility) where the participant has resided for 90-days or less AND the participant resided in an emergency shelter or place not meant for human habitation before entering the facility.)
- HUD Category 4: Fleeing/attempting to flee domestic violence (*Fleeing domestic violence, human trafficking, or sex trafficking*)
- Other Homeless (Please explain): \_\_\_\_\_



**LAHSA/DHS/DMH REFERRAL FORM FOR BRIDGE/INTERIM HOUSING/INTERIM HOUSING PROGRAM**

Client Name: \_\_\_\_\_

Client Date of Birth: \_\_\_\_\_

<p align="center"><b>Client Location</b></p> <input type="checkbox"/> SPA 1 – Antelope Valley <input type="checkbox"/> SPA 5 – West LA <input type="checkbox"/> SPA 2 – San Fernando Valley <input type="checkbox"/> SPA 6 – South LA <input type="checkbox"/> SPA 3 – San Gabriel Valley <input type="checkbox"/> SPA 7 – South East LA <input type="checkbox"/> SPA 4 – Metro LA <input type="checkbox"/> SPA 8 – South Bay	<p align="center"><b>Bridge/Interim Housing Placement Location</b></p> Willing to reside in a communal living environment*: <input type="checkbox"/> Yes <input type="checkbox"/> No Willing to reside in the Skid Row area: <input type="checkbox"/> Yes <input type="checkbox"/> No *Please note: most Interim Housing sites are communal living environments Any area(s) applicant CANNOT live in bridge/interim housing: _____
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<p align="center"><b>Authorization Forms</b></p> Do you have signed Authorization Forms? <input type="checkbox"/> Yes <input type="checkbox"/> No Are the Authorization Forms Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p align="center"><b>Service Animals</b></p> Does client have an animal that will accompany them to IH? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it a service animal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of animals: _____ Is it an emotional support animal(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of animals: _____ If so, what type(s) of animal(s)? _____
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<p align="center"><b>Mobility Issues</b></p> <input type="checkbox"/> Ambulatory (no impairments) <input type="checkbox"/> Cannot climb stairs <input type="checkbox"/> Uses walker/cane/crutches <input type="checkbox"/> Uses motorized wheelchair <input type="checkbox"/> Uses manual wheelchair <input type="checkbox"/> Cannot transfer independently <input type="checkbox"/> Other: _____	<p align="center"><b>Additional Assistance</b></p> <p align="center"><b>Check and describe below:</b></p> <input type="checkbox"/> None <input type="checkbox"/> Respiratory (supplemental oxygen) <input type="checkbox"/> Incontinence Issues <input type="checkbox"/> Reminders to take medications <input type="checkbox"/> Activities of Daily Living (hygiene/grooming) <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____
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**Please note if the client has any of the following issues/conditions listed below and mark the corresponding box(es): (Choose all that apply)**  
If medical is the client's primary issue, please provide additional details on the DHS/DMH Supplemental form (Attachment A) for any areas marked below.

Medical conditions     Mental Health issues     Recent Substance Use     Cognitive Impairments     Other Challenges/Issues  
 Client has none of the above referenced issues

**Any other information that may help match this individual to an appropriate bridge/interim housing placement:** \_\_\_\_\_

**If there is an urgent issue needing immediate attention, please describe:** \_\_\_\_\_

**TB Screening:**

Has the client had a cough recently that has lasted longer than 3 weeks?  Yes  No  Don't Know

Has the client recently lost weight without explanation during the past month?  Yes  No  Don't Know

Has the client had frequent night sweats during the past month, soaking your sheets or clothing?  Yes  No  Don't Know

Has the client coughed up blood in the past month?  Yes  No  Don't Know

Has the client been feeling much more tired than usual over the past month?  Yes  No  Don't Know

Has the client had fevers almost daily for more than one week?  Yes  No  Don't Know

*If client has a prolonged cough (> 3 weeks) plus any other TB symptoms, client must be promptly referred to an appropriate health care provider for an evaluation.*

TB Test Performed:  Yes  No Date: \_\_\_\_\_ Results: \_\_\_\_\_

Chest X-Ray Performed:  Yes  No Date: \_\_\_\_\_ Results: \_\_\_\_\_



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Client Name: \_\_\_\_\_

Client Date of Birth: \_\_\_\_\_

REFERRAL SUBMISSION INSTRUCTIONS: (please check one of the below choices)

IF CLIENT'S PRIMARY PRESENTING ISSUE IS MEDICAL:

Submit the completed LAHSA/DHS/DMH referral form for Bridge/Interim Housing and the Supplemental Form for DHS/DMH Interim Housing Program (Attachment A), the signed DHS Housing For Health and/or DMH Authorization for Use and Disclosure of Protected Health Information Form and if applicable, the additional supporting documentation as described in the Admission Guidelines and Referral Process for DHS/DMH Interim Housing Program to the designated contact at DHS to request placement.

- DHS - Ronnie Thomas
Email: InterimHousing@dhs.lacounty.gov
Phone: (213) 833-5370
Fax: (213) 895-6235
Alternate: Juataun Mark

IF CLIENT'S PRIMARY PRESENTING ISSUE IS A MENTAL HEALTH ISSUE:

Submit the completed LAHSA/DHS/DMH referral form for Bridge/Interim Housing and the Supplemental Form for DHS/DMH Interim Housing Program (Attachment A), the signed DHS Housing For Health and/or DMH Authorization for Use and Disclosure of Protected Health Information Form and if applicable, the additional supporting documentation as described in the Admission Guidelines and Referral Process for DHS/DMH Interim Housing Program to the designated contact at DMH to request placement.

- DMH - Gillian Hibbert
Email: IHP@dmh.lacounty.gov
Phone: (213) 480-3615
Alternate: Eric Smith

IF CLIENT'S PRIMARY PRESENTING ISSUE IS SUBSTANCE USE AND THE CLIENT IS INTERESTED IN SUBSTANCE USE TREATMENT:

Refer client to Substance Abuse Prevention and Control (SAPC) to request access to substance use treatment, including outpatient and residential services.

- SAPC - Substance Abuse Service Hotline (SASH)
Phone: (844) 804-7500

IF CLIENT HAS NONE OR FEW OF THE ABOVE REFERENCED ISSUES or doesn't need shelter services that provides health and/or mental health support, submit the completed LAHSA/DHS/DMH referral form for Bridge/Interim Housing to the designated contact at LAHSA to request placement.

- LAHSA - To be hired
Email: To be provided at a later date
Phone: To be provided at a later date
Alternate: To be provided at a later date

FOR LAHSA/DHS/DMH HOUSING STAFF ONLY

Reviewed by: \_\_\_\_\_ Dept.: LAHSA DHS DMH DPH Date: \_\_\_\_\_ Client ID: \_\_\_\_\_

Approved: Yes No Pending Further Information: Describe: \_\_\_\_\_

If denied, reason(s): \_\_\_\_\_

If approved, referred to: \_\_\_\_\_

Type of placement facility: LAHSA Bridge Housing LAHSA Crisis Housing DHS Stabilization Housing DHS Med RC DHS Psych/BH RC DMH IHP DPH Substance Use Disorder Treatment Facility

Other Placement Facility: \_\_\_\_\_

Responsible staff: \_\_\_\_\_ Dept.: LAHSA DHS DMH DPH Referral Date: \_\_\_\_\_

Notes: \_\_\_\_\_