

Los Angeles County Home Visiting Programs Confidential Referral Form



COUNTY OF LOS ANGELES
Public Health

Email completed form to: (encrypted) HomeVisit@ph.lacounty.gov OR
call 1-800-427-8700 (press #4, option #2), 213-639-6478 for assistance to complete form.
For a faster turn around please email to zramirez@pacsla.org

Referrals are accepted for any pregnant and/or parenting individuals who meet at least one criterion in the "Circumstances Needing Support" box below:

- Receiving CalWORKs
- Pregnant, if so EDD: _____
- First-time Pregnancy
- Parenting a child(ren) ages 0-kindergarten age. If so, child(ren)'s ages:
Child 1 DOB: _____ Child 2 DOB: _____

OPTIONAL: HV Model preference, if eligible:

- Healthy Families America (HFA)
- Nurse-Family Partnership (NFP)
- Parents As Teachers (PAT)

Is there any circumstance that qualifies referral for Doula Support Service? Yes No

Date: _____ Person making referral: _____ Title: _____

Is pregnancy known to family? (CONFIDENTIAL): Yes No Agency Name: _____

Email Address: _____ Phone: _____ Cell Phone: _____

Name of Client: _____ Date of Birth: _____ Email Address: _____

Home Address: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Other: _____

Preferred Language: _____ Race/Ethnicity: _____ English Speaking? Yes No Veteran? Yes No

Receiving Medi-Cal (MC): Yes No MC# _____ If no, is client Medi-Cal eligible? Yes No

Circumstances Needing Support: (Current OR History – Check ALL that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Mental health condition/diagnosis | <input type="checkbox"/> Medical diagnosis/complexity | <input type="checkbox"/> 19 years old or younger |
| <input type="checkbox"/> Maternal depression/anxiety | <input type="checkbox"/> Housing instability | <input type="checkbox"/> Foster care system |
| <input type="checkbox"/> Involvement with DCFS | <input type="checkbox"/> Exposed to trauma/violence/abuse | <input type="checkbox"/> Stressed Family |
| <input type="checkbox"/> Substance use | <input type="checkbox"/> Less than HS education or GED | <input type="checkbox"/> No Support System |
| <input type="checkbox"/> Entry into juvenile justice system | <input type="checkbox"/> Previous pre-term birth (Less than 37 weeks) | <input type="checkbox"/> IPV/DV |
| <input type="checkbox"/> Entry into criminal justice system | <input type="checkbox"/> Previous low birthweight baby (Less than 5lb, 8oz) | |
| <input type="checkbox"/> Adult and/or children with support needs:
Pls. Specify: _____ | <input type="checkbox"/> Unsafe physical living conditions:
Pls. Specify: _____ | <input type="checkbox"/> Other: _____ |

RELEASE AUTHORIZATION

I give permission to representatives of Los Angeles County Department of Public Health (LAC DPH), Division of Maternal, Child, and Adolescent Health (MCAH) and its contracted home visiting agencies to contact me regarding enrollment into one of its home visiting programs. I have been informed and do understand that LAC DPH representatives, its contracted home visiting agencies, and/or their contracted data administrators may use information on this form solely to determine prospective eligibility for services and assist in quality improvement and assurance of services provided through this referral process. I further understand that the data will be kept securely for seven (7) years, in compliance of HIPAA guidelines, whether I accept or decline services.

I have also been informed that should I have questions related to this release authorization and/or LAC DPH's policies relating to data safety, I may contact HomeVisit@ph.lacounty.gov or call at 213-639-6478. LAC DPH privacy practices can be reviewed at publichealth.lacounty.gov/docs/noticeofprivacy-eng.pdf.

Client consented to be referred to home visiting programs. Signature: _____ or Verbal

Comments: _____

LAC DPH Home Visitation Programs
Main Office: MCAH, 600 S. Commonwealth Ave. Suite 800, Los Angeles, CA 90005
Phone: (213) 639-6478

Revised Form (4/2024)
Please discard old forms

Clear Form