Los Angeles County Project HOPE Confidential Referral Form

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.

County of Los Angeles Public Health

Referrals are accepted for any homeless pregnant and/or parenting individuals who meet at least one criterion below:

- ☐ 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:
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: _____

Race/Ethnicity: _____ Veteran? ☐ Yes ☐ No

Preferred Language: _____ English Speaking? ☐ 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)

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

_____

Revised Form (5/2024)

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

Clear Form