REFERRAL FOR EXPEDITED IHSS APPLICATION FROM INTERIM HOUSING PROVIDER	
PART 1: REFERRING AGENCY INFORMATION	
CONTRACTED INTERIM HOUSING PROVIDER:	☐ DHS ☐ DMH ☐ LAHSA ☐ Other: ______
INTERIM HOUSING PROVIDER NAME:	
INTERIM HOUSING LOCATION:	
INTERIM HOUSING CONTACT PERSON:	Name: ______ Phone Number: ______ Email Address: ______
PART 2: IHSS APPLICANT INFORMATION	
APPLICATION DATE:	
NAME OF APPLICANT:	
DATE OF BIRTH:	
SOCIAL SECURITY NUMBER:	
PHONE NUMBER:	
TEMPORARY ADDRESS:	
PERMANENT ADDRESS:	
TARGET DATE FOR TRANSITION:	
LANGUAGE:	Spoken Language: ______ Written Language: ______
GENDER:	☐ Male ☐ Female
ETHNICITY:	
COMMUNICATION ACCOMMODATION NEEDED:	☐ Yes ☐ No If yes, describe what is needed (e.g., 18-point font forms, ASL interpreter, etc.): ______ ______
CURRENTLY RECEIVING MEDI-CAL?	☐ Yes ☐ No ☐ Not sure
SOC 873 INCLUDED: ☐ Yes ☐ No (To expedite processing of the IHSS application, whenever possible, please include the SOC 873, *In-Home Supportive Services [IHSS] Program Health Care Certification Form*.)	
PART 3: REFERRAL SUBMISSION	
INTERIM HOUSING PROVIDER LIAISON: ☐ DHS ☐ DMH ☐ LAHSA ☐ Other: ______	Name: ______ Phone Number: ______ Email Address: ______
DATE OF SUBMISSION TO DPSS LIAISONS:	

Instructions for Submission to DPSS:

Interim housing provider liaison will submit form to DPSS via secure email ***or*** fax:

Email: VilmaGonzalez@dpss.lacounty.gov *and* MeschelleBarnes@dpss.lacounty.gov
Fax: (213) 947-4591

Date received by DPSS staff: ______
IHSS Line Office referral forwarded to: ______
Date of referral to IHSS Line Office: ______