COUNTY OF LOS ANGELES — DEPARTMENT OF PUBLIC SOCIAL SERVICES

GENERAL RELIEF OPPORTUNITIES FOR WORK CLINICAL ASSESSMENT PROVIDER REFERRAL AND SERVICE RESULTS REPORT

GROW SITE:
ADDRESS:
DATE:
CASE NAME:
CASE NUMBER:

IMPORTANT APPOINTMENT NOTICE

The following appointment has been scheduled for you to attend a clinical assessment for mental health.	
Date of Appointment: ____________________ Time: ______________________________	Location: ____________________________________ Address: _____________________________________ Phone Number: ________________________________

IT IS IMPORTANT FOR YOU TO KEEP THIS APPOINTMENT
TAKE THIS NOTICE WITH YOU

If for any reason you cannot keep this appointment or have a problem, please contact me immediately.

GROW CASE MANAGER:	FILE NUMBER:	PHONE NUMBER:

SECTION A - PARTICIPANT INFORMATION

PARTICIPANT NAME:	CASE NUMBER:	
RESIDENCE ADDRESS:	MAILING ADDRESS (CONFIDENTIAL):	
PRIMARY LANGUAGE:	BIRTH DATE:	GENDER:
TELEPHONE NUMBER (CONFIDENTIAL):	SOCIAL SECURITY NUMBER:	

SERVICE RESULTS

SECTION B - COMPLETED BY CLINICAL ASSESSOR (Please complete and return to GROW Case Manager within five business days.)

RESULTS OF CLINICAL ASSESSMENT FOR ____:
PARTICIPANT NAME

❑ Participant did not appear/assessment not completed.

❑ Participant completed the assessment, but does not need a referral for treatment.

❑ Participant completed assessment and needs a referral, but does **not** agree to treatment for mental health.

❑ Participant completed assessment and agrees to recommended treatment for mental health. Please see below for appointment details:

Date of appointment: _______________ Location: _____________________________

Time: _____________________________ Address: _____________________________

Telephone Number: (____)__________

❑ Participant does not agree with completed assessment, requests third party assessment.
RECOMMENDED THIRD PARTY ASSESSMENT PROVIDER(S): include name, address, phone

1. ____

2. ____

3. ____

ASSESSOR SIGNATURE:	DATE:

SECTION C - COMPLETED BY GROW PARTICIPANT

I authorize the release of information to DPSS regarding the results of my assessment and possible need for treatment services.

❑ **Yes**, I agree to the service plan developed and agree to attend treatment.

❑ **No,** I do not agree to the service plan and will not attend treatment.

______________________________________ ____________________________
GROW Participant Signature Date