

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: _____
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**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:
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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