COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

GENERAL RELIEF OPPORTUNITIES FOR WORK

SUPPORTIVE SERVICES REFERRAL MHS

GROW SITE:
CASE NAME:
CASE NUMBER:
GCM FILE NUMBER:
TELEPHONE NUMBER:

You have been scheduled for a supportive services appointment for:

❒ Mental Health Services

Please report to the facility at the date and time listed below.

SECTION A (POPULATED BY MAPPER)

____
FACILITY NAME/LOCATION

______________________ ______________________
DATE TIME

SECTION B (TO BE COMPLETED BY SERVICE PROVIDER)

(Complete and return to GROW Case Manager within five business days following the appointment date)

❒ PARTICIPANT FAILED TO SHOW FOR APPOINTMENT

❒ PARTICIPANT SHOWED FOR APPOINTMENT

❒ FURTHER SERVICES ARE NOT REQUIRED

❒ PARTICIPANT ASSESSED AS NSA, SEND ABP 296 TO NOTIFY ELIGIBILITY WORKER

❒ TREATMENT BEGAN ON ________________

❒ EXPECTED DURATION __________________

❒ HOURS PER WEEK REQUIRED ___________

NAME OF PERSON COMPLETING FORM:	TITLE:

GROW CASE MANAGER:	TELEPHONE NUMBER:	FAX NUMBER:	DATE: