Health Services
LOS ANGELES COUNTY

# Enriched Residential Care Program

**Referrals, Assessment, and Placement (RAP) Team**

*Frequently Asked Questions*

**Who is eligible for ERC?**

Individuals with complex medical or behavioural health needs who require 24/7 care and supervision, assistance with activities of daily living but do not need nursing home–level care.

**What is RAP?**

- The Referrals, Assessment, and Placement (RAP) team connects vulnerable individuals who cannot live independently with safe, supportive housing in licensed residential care facilities across Los Angeles County.
- Referrals from PSH to ERC are referred to as Step Up.

**How does someone get referred to ERC?**

Referrals are completed via CHAMP. However, a referring party may contact the ERC RAP Team at ERC-Referrals@dhs.lacounty.gov for additional support. Most ERC referrals come from Interim Housing (IH), Permanent Supportive Housing providers (PSH), DHS hospitals, or other community partners.

**What are the required documents?**

An ERC referral and application consist of multiple forms including a Notice of Privacy Practices, Universal Consent Form, Request for ERC Assessment, Preplacement Appraisal Information (LIC603), Physician's Report LIC602/LIC602A (good for a year unless there has been new changes with the client's health) with a TB Test result (good for 6 months), medication list, Payment Responsibilities form and Income Verification (most recent, current year). All forms must be uploaded onto the client's CHAMP profile under "Documents/ERC Documents."

**What if completing a Physician's Report becomes a great challenge?**

It is the responsibility of the individual's referring party (point of contact) to support the individual with obtaining a completed Physician's Report (PR). It is best if the PR is completed by the individual's primary doctor or a physician familiar with the individual's medical history. If a PR cannot be retrieved, as a last resort, the referring party may communicate the need for further assistance from the RAP team. The RAP team may be able to loop-in one of ERC's Nurse Practitioners (NPs) to support with completing the individual's PR. This direction may still take some time as the ERC NP may have other appointments and responsibilities to attend to.

**What happens after a referral is made?**

The RAP team reviews the referred individual's application to confirm that all required forms are submitted. For any missing forms or information, the RAP team reaches out to the referring party for follow up support. After all forms are confirmed to be submitted, the RAP team schedules a comprehensive face-to-face assessment with the referred individual to determine the individual's needs, level of care, barriers & strengths, and clarify any questions that the individual may have on the ERC program.

**What types of housing are available through ERC?**

ERC's RAP team works to match individuals to licensed residential care facilities such as Adult Residential Facilities (ARFs) & Residential Care Facilities for the Elderly (RCFEs) that provide 24/7 supportive services, assistance with activities of daily living and medication management.

**How does RAP ensure the right placement?**

The RAP team collaborates with Facility Administrators (FAs), program managers, and care teams to make sure placements are person-cantered, safe, and sustainable. A referred individual's preferred region is always considered, but priority goes to a facility that may best support with the client's needs.

**What is the timeline for an ERC Referral and Placement?**

- Every ERC referral varies in timeline. If a referral continues to have missing forms after multiple reminders from the RAP Team, the individual's referral will be closed. The RAP team will keep the referral active for up to 30 days before deactivation.
- If a referral has all their required forms and the referred individual has been assessed by a RAP Program Manager, placement can be identified as soon as a week or a couple weeks. Timeline for placement also varies. A placement is determined by various factors such as facility availability, an individual's level of care (not all facilities can service the same levels of care, for example a client with dementia will require memory care and not all ERC facilities offer this support service), an individual's willingness to accept placement in a specific region, and individual not willing to consent and commit to ERC's payment responsibilities, etc. However, all updates with an individual's ERC referring process are communicated and shared with the point of contact(s).

**What services are provided once someone is placed?**

Residents receive support with daily living, medication management, case management, and coordinated medical & behavioural health services to promote stability and quality of life. All ERC participants are linked to our Wellness Team who work with participants to make sure they are receiving the appropriate care and support at our ERC facilities.

**Does RAP help explain ERC's financial responsibilities?**

Yes. All referred individuals are educated on ERC's rules and expectations including the program's payment responsibilities. Each ERC participant's financial contributions are different as amount is determined by the participant's current income status (ex: SSI, SSDI, GR, etc.).

**Can clients visit or tour facilities before moving in?**

Of course! When appropriate and upon request, RAP arranges site visits or tours with FAs, so clients understand their new living environment.

**What are the program's goals?**

ERC and the RAP Team aim to reduce hospitalizations, prevent homelessness, and improve the safety, dignity, and well-being of vulnerable individuals by ensuring timely, appropriate, and supportive placements.