Level of Care Utilization System (LOCUS) Request

Submit request via fax to (916) 854-8824. An incomplete request may be returned for additional information.

Referring Agency	
Submitting Program/Agency:	
Contact Person:	Phone Number:
Level of Care Requesting: ☐ High Intensity Outpatient Services ☐ Secured Setting	
Current Outpatient Provider	
Provider Agency:	Provider Program:
Contact Person:	☐ OP Provider is in agreement with a Higher Level of Care.
Phone Number: Date Contacted:	
Client Information	
Client Name:	Date of Birth:
Avatar ID/Medi-Cal# (CIN):	☐ Male: ☐ Female: ☐ Other: _____
Ethnicity:	Client's Preferred Language:
Conservator? ☐ Yes ☐ No	Type: ☐ LPS ☐ Probate
Conservator Name:	Phone Number:
Currently Hospitalized (Psychiatric)? ☐ Yes ☐ No	If yes, reason: ☐ DTS ☐ DTO ☐ GD
Primary Diagnosis: 1)_____ 2)_____	
Reason for Higher Level of care Request (include current presenting symptoms/behavior):	
Documents Attached: ☐ Medication List ☐ Assessment ☐ Other: _____	
Co-occurring substance use (If applicable, please list): Tested Positive at Admission (for Inpatient use)? ☐ Yes ☐ No	
Current Housing: ☐ Independent Living ☐ Family ☐ Room and Board ☐ Board and Care ☐ Temporary Housing ☐ Other: _____ Can return to that residence?: ☐Yes ☐No	
Insurance: ☐ Medi-Cal ☐ Medicare ☐ Uninsured ☐ Other: _____ Funding/ Income: _____	
Support system: ☐Family ☐Peer(s) ☐Volunteer/Employment ☐ Spiritual/Religious ☐NA/AA	
For Kaiser Members Only:	
Kaiser Contact Approving:	Phone Number:
Kaiser OP Contact:	Phone Number:
County Services Requested/Intensive Community-Based: ☐Rehabilitation ☐Case Management ☐Psychiatric Medication Services ☐Other: _____	