## HOUSING DEPOSITS REFERRAL FORM



Send to CareManagement\_Referrals@sfhp.org

Housing Deposits are Community Support Services offered to eligible Medi-Cal members to assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board. **Housing Deposits are available once in an individual's lifetime.** 

If this is a self-referral, please call SFHP's Care Management Intake line during business hours of 8:30am—5:00pm, Monday—Friday: **1(415) 615-4501**, and an SFHP staff member can assist you.

If the referral is being completed by a provider or other agency, please complete this form, and securely email to San Francisco Health Plan's Care Management department at **caremanagement\_referrals@sfhp.org**.

MEMBER/PATIENT INFORMATION  Member must already be enrolled with SFHP for their Medi-Cal coverage						
First Name:	Last Name:					
Date of Birth (MM/DD/YYYY):	Preferred Language:					
SFHP ID#:	Referral Date:					
Primary Phone Number:	Alternate Phone Number:					
Address:						
REFERRING ENTITY INFORMATION						
<ul> <li>□ PCP/Specialist</li> <li>□ Community Based Organization</li> <li>□ Community Supports Provider</li> <li>□ ECM provider</li> </ul>	☐ Friend/Family ☐ Hospital ☐ Self ☐ Other (please specify):					
Name:	Phone Number:					
Address:	Email:					

## HOUSING DEPOSITS REFERRAL FORM

Signature:



Send to CareManagement\_Referrals@sfhp.org

	IGIDILIT CRITERIA
1.	Is the member currently receiving Housing Navigation Transition Services?  No If No is checked, STOP. Member does not meet eligibility requirement. Instead, refer the member to Housing Navigation Community Supports.  Yes  If Yes, identify the Navigation Services provider:
2.	Which of the following are reasonable and necessary to enable the member to establish a basic household (select all that apply)?  Security deposit (or first and/or last month's rent)  Utility deposit (electricity, water, garbage)  Furniture  Home goods
3.	Is the member able to meet the above expenses without Housing Deposits Community Support?  □ No □ Yes
4.	Additional documentation that is required to be eligible:  ☐ Signed and dated lease or rental agreement ☐ Landlord's W9 (if security deposit is a requested expense) ☐ Member's individualized housing support plan
ΑT	TESTATION STATEMENT
	I, the referent, attest that to the best of my knowledge; the member meets the eligibility criteria and does not fall within the exclusion criteria.

Today's Date (MM/DD/YYYY):

Form last updated: 12/2024 0010520 1224

## **COMMUNITY SUPPORTS PRIOR APPROVAL FORM**

FOR HOUSING DEPOSITS, HOME MODIFICATION, AND COMMUNITY TRANSITION SERVICES SEND TO CareManagement Referrals@sfhp.org



## NOTE: ALL FIELDS MARKED WITH AN ASTERISK (\*) ARE REQUIRED

		TYPED ONLY - NO HA	ANDWRITTEN F	ORMS				
Select all th	nat apply:   New Request   M	odify Prior Request						
Select appli	icable CS service:   Housing Depo	osits   Home Modifications	s 🗆 Community Tr	ransitions Service	(At least one vali	id CS service is r	equired)	
PATIENT			RENDERING PRO	VIDER				
Name*:			Name*:					
SFHP ID#*: Date of Birth*:			Telephone*:					
Telephone:	Telephone:		Contact Name: Fax:					
Address:			Address:					
JUSTIFY TI	HE GOODS/SERVICES AND DESC	CRIBE HOW THEY MEET ME	MBER NEEDS*					
COMMUN	ITY SUPPORTS SERVICE TYPES							
	Deposits	s □ Community Transitions	Service (At least one	valid CS service is rec	uired)			
QTY OF ITEM	NAME OF ITEM	DESCRIPTION	V	ENDOR (Amazon, IK	(EA, etc.)	COST PER UNIT	TOTAL COST	
			:				••••••••	
:			: : : :	• • • • • • • • • • • • • • • • • • • •				
			······································	• • • • • • • • • • • • • • • • • • • •	,			
······································			······ :	• • • • • • • • • • • • • • • • • • • •			• • • • • • • • • • • • • • • • • • • •	
:			······································	• • • • • • • • • • • • • • • • • • • •			• • • • • • • • • • • • • • • • • • • •	
				• • • • • • • • • • • • • • • • • • • •	,			
Δuthorizatio	ons are based on medical necessit	: v and covered services Author	rizations are continu	nent unon memb	er's eligibility a	ind henefits a	and are not	
a guarante	e of payment. The provider is resp nethods: 1. Web: <b>sfhp.org/provid</b>	onsible for verifying member	's eligibility on the d	date of service. P	lease verify elig	gibility using	one of the	
Comments:				• • • • • • • • • • • • • • • • • • • •		••••••		
Signature*:			Submiss	sion Date*:		• • • • • • • • • • • • • • • • • • • •		

**Important:** Please attach appropriate documentation to support your request.