

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

PCP/Specialist

Friend/Family

Community Based Organization

Hospital

Community Supports Provider

Self

ECM provider

Other (please specify):

Name:

Phone Number:

Address:

Email:

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ELIGIBILITY 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

ATTESTATION 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.

Signature:

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