HOUSING DEPOSITS REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

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 San Francisco Health Plan's Care Management Intake line during business hours of 8:30am–5:00pm, Monday–Friday: **1(415) 615-4515,** 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 *Required fields

- ■ PCP/Specialist
- ☐ Community Based Organization
- ☐ Community Supports Provider
- ☐ ECM Provider
- ☐ Medical Officer
- ☐ Friend/Family
- ☐ Hospital
- ☐ Self
- ☐ Social Services Provider
- ☐ Other: (please specify)

*Referring Individual Name:	*Referring Individual Title:
*Referring Individual Phone Number:	*Referring Individual Email Address:
*Referring Organization Name:	*Referring Individual National Provider Identifier (NPI):

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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

Additional comments:

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):

COMMUNITY SUPPORTS PRIOR APPROVAL FORM

FOR HOUSING DEPOSITS, HOME MODIFICATION, ASSITED LIVING FACILITY TRANSITIONS AND TRANSITION TO COMMUNITY SERVICES

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

TYPED ONLY - NO HANDWRITTEN FORMS

Select all that apply: ☐ New Request ☐ Modify Prior Request

Select applicable CS service: ☐ Housing Deposits ☐ Home Modifications ☐ Community Transitions Service (At least one valid CS service is required)

PATIENT		RENDERING PROVIDER	
Name*:		Name*:	
SFHP ID#*:	Date of Birth*:	Telephone*:	
Telephone:		**Contact Name:**	Fax:
Address:		Address:	

JUSTIFY THE GOODS/SERVICES AND DESCRIBE HOW THEY MEET MEMBER NEEDS*

COMMUNITY SUPPORTS SERVICE TYPES

☐ Housing Deposits ☐ Home Modifications ☐ Community Transitions Service (At least one valid CS service is required)

QTY OF ITEM	NAME OF ITEM	DESCRIPTION	VENDOR (Amazon, IKEA, etc.)	COST PER UNIT	TOTAL COST

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service. Please verify eligibility using one of the following methods: 1. Web: **sfhp.org/providers** 2. Interactive Voice Response: **1(415) 547-7810** 3. SFHP Customer Service: **1(800) 288-5555**

Comments:

Signature*: Submission Date*:

Important: Please attach appropriate documentation to support your request.