HOUSING TENANCY AND SUSTAINING SERVICES REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
Here for you

Housing Tenancy and Sustaining Services are Community Support Services offered to eligible Medi-Cal members to maintain safe and stable tenancy once housing is secured for members who previously experienced homelessness or were recently at-risk of homelessness.

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. **Which best describes the client being referred for services** (must select at least one):
   - ☐ Previously homeless, recently housed, received Housing Transition/Navigation Services
   - ☐ Prioritized for a permanent supportive housing unit or rental subsidy through the Coordinated Entry System
   - ☐ Experiencing homelessness **and at least one of the following** (select all that apply):
     - ☐ Is receiving Enhanced Care Management (ECM)
     - ☐ Has one or more serious chronic conditions
     - ☐ Has a serious mental illness
     - ☐ Is at risk of institutionalization or requires residential services for a substance use disorder
   - ☐ Is at-risk of homelessness (has notice that current living situation will end within 21 days) **and at least one of the following** (select all that apply):
     - ☐ Has one or more serious chronic conditions
     - ☐ Has a serious mental illness
     - ☐ Is at risk of institutionalization or requires residential services for a substance use disorder
     - ☐ Is receiving Enhanced Care Management (ECM)
     - ☐ Is a Transitional Aged Youth (TAY) with significant barriers to housing stability

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):