# TRANSITIONAL RENT SERVICES REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

Transitional Rent Services are Community Support Services offered to eligible Medi-Cal members providing up to six months of rental assistance in interim and permanent settings to members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

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) 615-4515,** 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 fax to **1(415) 615-6400** or 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

*Are required fields

| | |
|---|---|
| ☐ PCP/Specialist | ☐ Friend/Family |
| ☐ Community Based Organization | ☐ Hospital |
| ☐ Community Supports Provider | ☐ Self |
| ☐ ECM provider | ☐ Social Services Provider |
| ☐ Medical Officer | ☐ Other (please specify): |
| Referring Individual Name*: | Referring Individual Title*: |
| Referring Individual Phone Number*: | Referring Individual Email*: |
| Referring Organization Name*: | Referring Organization NPI*: |

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## ELIGILITY CRITERIA

Member must meet all criteria below

1. **Which of the following qualifying clinical factors does the member have?**
   - ☐ Member meets access criteria for drug Medi-Cal or Drug Medi-Cal Organized Delivery System
   - ☐ Member meets access criteria for Medi-Cal Specialty mental health
   - ☐ Member has one or more serious chronic physical health conditions
   - ☐ One or more physical, intellectual, or developmental disabilities
   - ☐ Is pregnant up through 12-months postpartum

2. **Is the member experiencing or at risk for homelessness AND one of the following apply?**
   - ☐ Transitioning out of an institutional or congregate residential setting
   - ☐ Transitioning out of a carceral setting
   - ☐ Transitioning out of an interim housing
   - ☐ Transitioning out of recuperative care or short-term post hospitalization housing
   - ☐ Transitioning out of foster care

3. **If no to any in #2, which of the following apply?**
   - ☐ Member is experiencing unsheltered homelessness
   - ☐ Is eligible for Full-Service Partnership (FSP)

## 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 TRANSITIONS, TRANSITION TO COMMUNITY AND TRANSITIONAL RENT SERVICES**

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

**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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |

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**

Justify the goods/services and describe how they meet member needs:

Signature*: Submission Date*:

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