

HOUSING DEPOSIT REFERRAL FORM

Housing Deposits Services provide assistance with funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board. For more information, review the [Housing Deposit Authorization Guide](#) and the [Housing Deposit Item List Example](#).

Complete and submit this referral form with the *Outpatient Medicaid – Prior Authorization Fax Form* either online (recommended) at **www.CAHealthWellness.com** or by fax at **866-724-5057**.

<input type="checkbox"/> Initial request <input type="checkbox"/> Extension request <input type="checkbox"/> Member consented to Housing Deposit referral.	
Eligibility Criteria	
Member must meet <u>one</u> of the following: <input type="checkbox"/> Member who received Housing Transition and Navigation services <input type="checkbox"/> Member who is matched to a publicly funded permanent supportive housing resource or rental subsidy resources through the local Coordinated Entry System or similar system <input type="checkbox"/> Member who meets the HUD definition of homelessness	
Additional Eligibility Criteria	
Has the member previously received Housing Deposit Community Support services from a California Medi-Cal health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much of the \$6,000 lifetime maximum benefit has the member used? <input type="checkbox"/> All (full \$6,000) <input type="checkbox"/> Partial amount used: \$ _____ Please provide an explanation of this extension request: _____	
1. Has the member's assigned housing provider identified a reasonable and necessary financial need that requires Housing Deposit assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is member moving into permanent housing? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide move-in date) Move-in date: _____	
Member Information	
Member name:	Date of birth (DOB):
Medi-Cal ID:	Preferred language:
Home address:	Phone number:
Contact name: (if different than member)	Relationship:
Phone number:	Preferred language:

Community Supports Provider Information (Servicing Organization)

Organization name:

Tax identification (ID):

National Provider Identifier (NPI):

Staff name:

Title:

Phone number:

Fax number:

Requested Items

Please check off each box the member is requesting assistance for and provide required documents.

Member's Individualized Housing Support Plan that explicitly indicates the need for Housing Deposits Services must be submitted in addition to other required documents.

Requested Items	Required Documents
<input type="checkbox"/> Security deposits	<input type="checkbox"/> Lease with the member's name, amount for security deposit and move-in date
<input type="checkbox"/> Utility setup/deposit fees or utility bills	<input type="checkbox"/> Utility bill (must include all pages and the member's name must match)
<input type="checkbox"/> First/last month rent amount	<input type="checkbox"/> Lease with the member's name and the rent amount
<input type="checkbox"/> Goods	<input type="checkbox"/> Pre-purchase: online shopping cart itemized list All shopping cart itemized lists and receipts must be kept in the member's record for auditing purpose.
<input type="checkbox"/> Cleaning/pest or other service required for move-in	<input type="checkbox"/> Quote service cost
<input type="checkbox"/> Medically necessary adaptive aids and services	<input type="checkbox"/> Medi-Cal DME denial letter <input type="checkbox"/> Receipts do not need to be submitted to the Plan, but must be kept in the member's records for auditing purpose

Total amount requested: \$ _____

Please round all costs up to the nearest full dollar amount.

Maximum allowance including taxes must not exceed \$6,000.00.

Additional Comments: