# Housing Deposits Services Request for Funds Form

Housing Deposits Services provides 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.

**Only L.A. Care Housing Deposits Providers can submit this form**. This form is only for eligible L.A. Care Medi-Cal and Cal Medi-Connect members. Please refer to the L.A. Care Housing Deposit Quick Reference Guide for more information. This form is **NOT** for members from Anthem, Blue Shield Promise, or Kaiser.

## Eligibility Criteria Attestation:

☐ L.A. Care Medi-Cal or Cal Medi-Connect member; and

☐ Enrolled in and receiving housing navigation services through Homeless and Housing Support Services (HHSS); and

☐ Currently in the process of moving into permanent housing; and

☐ Unable to meet requested housing deposit expenses.

## Member Information

Request Date:

M M / D D / Y Y Y Y

Member ID/CIN:

0 1 2 3 4 5 6 7 8 9

Member First Name:

Member Last Name:

HMIS #:

0 1 2 3 4 5 6 7 8 9

CHAMP ID # (if known)

0 1 2 3 4 5 6 7 8 9

## Member Attestation

☐ Member consented to disclosure of this information to L.A. Care.

☐ Check this box to confirm that Housing Deposits Community Supports Services shall supplement and not supplant services received by the member through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

## Service Information

Servicing Provider Organization Name:

NPI:

0 1 2 3 4 5 6 7 8 9

Referrer Email Address:

Name of Referrer (First and Last):

Contact Phone Number:

Return Fax Number:

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# Housing Deposits Services Request for Funds Form

## For the Housing Provider to complete

Enter date member was enrolled/opted-in into HHSS

| M | M | / | D | D | / | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

1. Is this an Initial Request?
   - ☐ Yes
   - ☐ No (If No, please provide reason for follow up request)

     _____

     _____

2. Has member received other housing deposit services from other California Medi-Cal health plans?
   - ☐ Yes (If yes, please provide previous information below)

     *Housing Deposits Services provider name*:

     | | | | | | | | | | | | | | |
     |---|---|---|---|---|---|---|---|---|---|---|---|---|---|
     | | | | | | | | | | | | | | |

     *California Medi-Cal health plan name*:

     | | | | | | | | | | | | | | |
     |---|---|---|---|---|---|---|---|---|---|---|---|---|---|
     | | | | | | | | | | | | | | |

   - ☐ No

3. Has the assigned HHSS provider completed an Individualized Housing Support Plan?
   - ☐ Yes
   - ☐ No

4. Has the member's assigned HHSS provider identified a reasonable and necessary financial need that requires move-in assistance?
   - ☐ Yes
   - ☐ No

5. Is member moving into permanent housing?
   - ☐ Yes (If Yes, please provide move-in date)

     | M | M | / | D | D | / | Y | Y | Y | Y |
     |---|---|---|---|---|---|---|---|---|---|
     | | | | | | | | | | |

   - ☐ No

☐ By checking this box, you are attesting that all information provided on this form has been validated. Also, where indicated on this form that you have captured "**member consent**" you will be able to present documentation substantiating this claim with dates, times, signature, voice capture, and/or phone records which will be required upon any prospective audit.

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**Identified Needs:** Please check off each item the member needs along with the identified "Amount Requested". Once completed, sum all your "Amount Request" and add the grand total at the bottom. **Please round all cost up to the full dollar amount**.

## Rental Payment

Rental Payment as required by landlord for occupancy. No allowance maximum for this section."

| Service Type & Description | Amount Requested |
|---|---|
| ☐ Security Deposit | $ , |
| ☐ First Month's Rent | $ , |
| ☐ Last Month's Rent | $ , |

## Utilities

Set-up fees/deposits for utilities or service access and utility arrearages. No allowance maximum for this section.

| Service Type & Description | Amount Requested |
|---|---|
| ☐ Utility Deposit | $ , |
| ☐ Electricity | $ , |
| ☐ Heating | $ , |
| ☐ Gas | $ , |
| ☐ Water | $ , |

## Cleaning Services

Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy. Maximum Allowance for fumigation and cleaning: combined total of $400.00

| Service Type & Description | Amount Requested |
|---|---|
| ☐ Fumigation | $ |
| ☐ Cleaning Service | $ |

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# Housing Deposits Services Request for Funds Form

## Medically-Necessary Adaptive Aids

If the member's Medi-Cal health plan/delegated medical group has denied DME, submit request and provide DME denial letter as a supporting document.

| Service Type & Description | Amount Requested |
|---|---|
| ☐ Hoyer Lift | $ , |
| ☐ Hospital Bed | $ , |
| ☐ Shower Chair | $ , |
| ☐ Bedside Commode | $ , |

## Approved Goods

Goods designed to preserve an individuals' health and safety in the home that are necessary to ensure access and safety for the individual upon move-in to the home. Maximum allowances includes taxes.

| Service Type & Description | Amount Requested |
|---|---|
| ☐ Air Conditioner (Max $250) | $ |
| ☐ Bed Frame (Max $200 per bed frame needed) | $ , |
| ☐ Heater (Max $100) | $ |
| ☐ Mattress (Max $350 per mattress needed) | $ , |
| ☐ Microwave (Max $125) | $ |
| ☐ Refrigerator (Max $800) | $ |
| ☐ Stove (Max $700) | $ |
| ☐ Dining Table and 2 Chairs (Max $300) | $ |
| ☐ Couch (Max $500) | $ |
| ☐ Infant Furniture (Max $300) | $ |
| ☐ General Home Goods (Max $300) (i.e. bathroom kit, kitchen, bedroom) | $ |
| **Grand Total including taxes must not exceed $6,000.00** | $ , |

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

☐ Member's Individualized Housing Support Plan that explicitly indicates the need for Housing Deposits Services

| | |
|---|---|
| ☐ Security Deposits | ☐ Lease with member's name, the amount for Security Deposits, and move in date *or*<br>☐ Intent to Rent OR RFTA (Request for Tenancy Approval) with member's name and the amount for Security Deposits *or*<br>☐ Unit Inspection Documentation |
| ☐ Utility Setup/Deposit Fees or Utility Bills | ☐ Utility Bill (must include all pages and member's name must match) |
| ☐ First/Last Month Rent Amount | ☐ Lease with member's name and the rent amount |
| ☐ Goods | ☐ Receipts do not need to be submitted to L.A. Care, but must be kept in member's records for auditing purposes |
| ☐ Cleaning/Pest or other service required for move-in | ☐ Invoice – Service Cost |
| ☐ Medically – Necessary adaptive aids and services | ☐ Medi-Cal DME Denial Letter<br>☐ Receipts do not need to be submitted to L.A. Care, but must be kept in members records for auditing purposes |

## Additional Notes and Concerns

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**This Request Does Not Guarantee Eligibility. Check Eligibility Prior To Rendering Service.**
**Payment Will Not Be Made For Unauthorized Services.**
**Secure Fax (213-536-0630).**