Homeless and Housing Support Services Program (HHSS) Form

L.A. Care Health Plan's Homeless and Housing Support Services (HHSS) provides two services to eligible members: housing navigation and tenancy services. HHSS is a part of L.A. Care's health services called Community Supports. To submit an authorization request, all required fields in this form must be completely filled out and submitted via Secure Fax (**213.536.0630**). If the Secure Fax is not accessible, please submit via Secure Email (**HHSS-Referrals@lacare.org**).

This form is only for L.A. Care Medi-Cal and Dual Eligible Special Needs Plan members. This form is NOT for members from Anthem or Blue Shield Promise. Please refer to the L.A. Care HHSS Eligibility Criteria for more information.

Required responses are identified with an asterisk.*

Please check the type of service the member is requesting (choose one only):*

1. ☐ Housing Navigation – services to help homeless members and members at-risk of homelessness find housing
2. ☐ Tenancy Services – services to help homeless members and members at-risk of homelessness maintain housing

☐ Check this box if there has been a change in the member's service (must complete Section G)

Referral Source Information (Section A)

Date of Referral:* _____

Internal referring department* (select one): ☐ BH ☐ CM ☐ CRC ☐ ECM ☐ MLTSS ☐ SS ☐ Other: _____

External referral by* (select one): ☐ ECM provider ☐ Homeless Provider ☐ Hospital ☐ PCP/Clinic ☐ PPG ☐ Other:_____

Referring Individual Name:* _____

Referring Organization Name:* _____

Referring Organization Address:* _____

Referring Fax Number:* ( ) _____

Referrer Phone Number:* ( ) _____

Referrer Email Address:* _____

HHSS Provider NPI:* _____

For Referring Individual to complete (Section B)

☐ Check here if you have obtained "Member Consent" to enroll (Opt-In) into LA CARE HEALTH PLAN's Homeless and Housing Support Services (HHSS) Program and 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.*

Is the member transitioning their Housing Navigation or Tenancy Services due to a change in their health plan?*

☐ Yes ☐ No

If Yes, please confirm previous enrollment information below:

Housing Navigation or Tenancy Services provider name: _____

California Medi-Cal health plan name: _____

Last date the member worked with previous Housing Navigation or Tenancy Services Provider:_____

L.A. Care HEALTH PLAN®

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Member Information (Section C)

First Name:* _____ Last Name:* _____

Medi-Cal Client ID# (CIN):* _____ ☐ L.A. Care Medi-Cal:* ☐ Dual Eligible Special Needs Plans*

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other _____

Preferred Language:* _____ Date of Birth:* _____

Primary Phone Number:* ( ) _____ HMIS I.D. if available: _____

Authorized Representative Name: _____ Phone Number: ( ) _____

Elgibility Criteria (Section D)

☐ Member is prioritized for Permanent Supportive Housing (PSH); **OR**

☐ Member meets the homelessness criteria; **OR**

☐ Member meets the at-risk of homelessness criteria

Additional Eligibility Criteria [at least one box must be checked for approval] (Section E)

☐ Member has one or more serious chronic conditions (list below); AND/OR

☐ Member has serious mental illness (list below); AND/OR

☐ Are at-risk of institutionalization or overdose or are requiring residential services as a result of a substance use disorder (list below); AND/OR

☐ Are receiving Enhanced Care Management

List the serious chronic condition(s), mental illness(es), or substance use disorder(s): _____

_____

For more information on the eligibility criteria, please visit our website. Click Here

Member Housing Status Information (Section F)

Current living location:*

If you selected Other, please specify: * _____

Current SPA location:*

Mailing address or location:* _____

Change in Member's Housing Status (Section G)

If member has been permanently housed, please include the new address.

_____

Please indicate when the member moved in: _____ /_____ /_____

If member is no longer in PSH, please provide move out date: _____ /_____ /_____

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Please share any additional information on the member's housing status and housing needs:

By submitting this authorization request form, I attest that the information above is true and accurate to the best of my knowledge.

Note: Please complete the L.A. Care's Homeless and Housing Support Services (HHSS) Reauthorization Form for reauthorization of services