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 a referral, 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 Plans members. This form is NOT for members from Anthem, Blue Shield Promise, or Kaiser. Please refer to the L.A. Care HHSS Eligibility Criteria for more information.

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

1. ☐ Housing Navigation – services to help homeless members find housing
2. ☐ Tenancy Services – services to help formerly homeless members keep their housing

Referral Source Information

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:

☐ 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

First Name:* _____ Last Name:* _____

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

Preferred Language:* _____ Date of Birth:* _____

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other_____

Mailing address or location:* _____

If member is moving into new address, please include new address.

_____

Primary Phone Number:* ( ) _____ Best Time to Contact:* _____

Authorized Representative Name: _____ Phone Number:* ( ) _____

Member Housing Status Information

If requesting for Housing Navigation Services, the Member must meet one of the following homeless statuses. Select one that applies:*

☐ Member who meets the HUD definition of homelessness; or

☐ Member is exiting an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and would become homeless immediately upon release; or

☐ Member who meets HUD definition of chronic homelessness; or

☐ Member is matched to a publicly funded permanent supportive housing resource or program in Los Angeles County.

If requesting for Tenancy Services, the Member must meet one of the following homeless status. Select one that applies:*

☐ Member who received Housing Navigation Community Supports prior to entering housing; or

☐ Member who met the HUD definition of homelessness prior to entering housing and has been housed for less than six months; or

☐ Member who has exited from an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and has been housed for less than six months; or

☐ Member who met HUD chronic homelessness definition prior to entering housing and has been housed for less than two years; or

☐ Member is participating in a publicly funded permanent supportive housing resource or program in Los Angeles County.

Current Living Location:* ☐ Interim Housing ☐ Permanent Supportive Housing ☐ Shelter ☐ Vehicle
☐ Skilled Nursing Facility / Long Term Care ☐ Street ☐ Other, please specify:_____

Address for current living location:* _____

Current SPA location:*

☐ SPA 1: Antelope Valley
☐ SPA 2: San Fernando Valley
☐ SPA 3: San Gabriel Valley
☐ SPA 4: Metro LA
☐ SPA 5: West
☐ SPA 6: South
☐ SPA 7: East
☐ SPA 8: South Bay

Is the member matched to a housing program, housing voucher, or other publicly funded housing opportunity?*

☐ Yes: Please describe _____ ☐ No

Is member able to live independently?* ☐ Yes ☐ No

Provide Member's CHAMP I.D. if available: _____

Provide Member's HMIS I.D. if available:_____

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

Member Health Information

Does the member have any of the below health conditions?* ☐ Yes ☐ No ☐ Unknown

☐ Asthma, ☐ Coronary artery disease *(includes stroke and heart attack/MI)*, ☐ Chronic/congestive heart failure, ☐ Chronic obstructive pulmonary disease *(includes emphysema)*, ☐ Diabetes, ☐ Epilepsy, ☐ Hypertension, ☐ Chronic liver disease *(includes Hepatitis B and Hepatitis C)*, ☐ Alcohol use disorder, ☐ Chronic kidney disease, ☐ Other substance use disorders, ☐ Dementia, ☐ Traumatic brain injury, ☐ Bipolar disorder, ☐ Major depressive disorder, ☐ Psychotic disorder *(includes schizophrenia)*, ☐ Other serious mental illness ☐ Any cancer under treatment, except basal cell carcinoma *(skin cancer)*, ☐ HIV, ☐ Lupus, ☐ and Rheumatoid arthritis

How many Emergency Department visits did the member have in the last year?* Insert number of visits: _____ ☐ Unknown

How many Inpatient visits did the member have in the last year?* Insert number of visits: _____ ☐ Unknown

Please share any additional information on the member's health needs:

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