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:

L.A. Care HEALTH PLAN®

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.

L.A. Care HEALTH PLAN®

Housing Deposits Services Request for Funds Form

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	$

L.A. Care HEALTH PLAN®

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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	$,

L.A. Care HEALTH PLAN®

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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* ☐ Intent to Rent OR RFTA (Request for Tenancy Approval) with member's name and the amount for Security Deposits *or* ☐ 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 ☐ 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).