



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. Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage.

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

Member Eligibility Criteria Attestation:

- L.A. Care Medi-Cal or D-SNP member; and
- Enrolled in and receiving housing navigation services through Housing Navigation or Tenancy Sustaining Services (HN/TSS); 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
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Member First Name:

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Member Last Name:

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Member ID CIN:

0	1	2	3	4	5	6	7	8	9
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HMIS #:

0	1	2	3	4	5	6	7	8	9
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CHAMP ID # (if known)

0	1	2	3	4	5	6	7	8	9
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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:

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NPI:

0	1	2	3	4	5	6	7	8	9
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Referrer Email Address:

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Name of Referrer (First and Last):

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Contact Phone Number:

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Return Fax Number:

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For the Housing Provider to complete

Enter date member was enrolled/opted-in into HN/TSS

M	M	/	D	D	/	Y	Y	Y	Y
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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:

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California Medi-Cal health plan name:

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- 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
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- No

If no, stop here. Member is not eligible for Housing Deposits.



Landlord Deposit Exemption Attestation: (if requesting rent deposit)

Effective 7/1/2024, California residential property owners may only collect up to 1-month of rent as part of the security deposit. An exemption will apply to certain small property owners with no more than two (2) residential rental properties (collectively including no more than four (4) dwelling units offered for rent), who may still collect up to 2-months rent as a security deposit.

If property owner meets **all three** of the following for exemption, Provider may request up to 2-months rent as part of security deposit (e.g. first and last):

- Property owner is a natural person, a limited liability company (in which all members are natural persons), or a family trust; AND
- Property owner owns no more than two residential rental properties that collectively include four or fewer units. For example: one fourplex, two duplexes, or two single-family homes; AND
- The Member is not on active military duty

If property owner does not meet the above three criteria or it is unconfirmed Provider may only request up to 1-month rent as part of security deposit.

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- 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.



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
<input type="checkbox"/> Security Deposit	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> First Month's Rent	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Last Month's Rent	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Move-In Cost (e.g. moving service, moving vehicle rental)	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Utilities

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

Service Type & Description	Amount Requested
<input type="checkbox"/> Utility Deposit	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Electricity	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Heating	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Gas	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Water	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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
<input type="checkbox"/> Fumigation	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Cleaning Service	\$ <input type="text"/> <input type="text"/> <input type="text"/>



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
<input type="checkbox"/> Hoyer Lift	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Hospital Bed	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Shower Chair	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Bedside Commode	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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
<input type="checkbox"/> Air Conditioner (Max \$250)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Bed Frame (Max \$200 per bed frame needed)	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Heater (Max \$100)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Mattress (Max \$350 per mattress needed)	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Microwave (Max \$125)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Refrigerator (Max \$800)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Stove (Max \$700)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Dining Table and 2 Chairs (Max \$300)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Couch (Max \$500)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Infant Furniture (Max \$300)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> General Home Goods (Max \$300) (i.e. bathroom kit, kitchen, bedroom)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
Subtotal including taxes must not exceed \$6,000.00	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Administrative Cost (\$60)	\$ <input type="text"/> <input type="text"/> <input type="text"/>
GRAND TOTAL	\$ <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



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
[IHSP must be included at the time of submission of this form]

Security Deposits

Move-in costs

Lease with member’s name, the amount for Security Deposits, and move in date

Receipts do not need to be submitted to L.A. Care, but must be kept in member’s records for auditing purposes

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

**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).**