

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:	Member ID/CIN:
M M / D D / Y Y Y Y	0 1 2 3 4 5 6 7 8 9
Member First Name:	HMIS #:
	0 1 2 3 4 5 6 7 8 9
Member Last Name:	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.

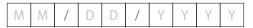
Service Information

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For the Housing Provider to complete

Enter date member was enrolled/opted-in into HHSS



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?

Housing Deposits Services provider name:

California Medi-Cal health plan name:

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🗆 No

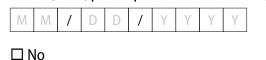
3. Has the assigned HHSS provider completed an Individualized Housing Support Plan?

□ Yes

□ No

- 4. Has the member's assigned HHSS provider identified a reasonable and necessary financial need that requires move-in assistance?
 - 🗆 Yes

□ No



□ 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
□ 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	\$



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 <mark>(Max \$300)</mark>	\$
□ General Home Goods (Max \$300) (i.e. bathroom kit, kitchen, bedroom)	\$
Grand Total including taxes must not exceed \$6,000.00	\$,



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

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).