

**Member Eligibility Criteria Attestation:** 

### **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.

☐ L.A. Care Medi-Cal or D-SNP member; and			
☐ Enrolled in and receiving housing navigation services through H			
☐ Currently in the process of moving into permanent housing	y; 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 HN/TSS

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
	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

sec	urity	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
		erty owner does not meet the above three criteria or it is unconfirmed Provider may only request up to h rent as part of security deposit.
	•	checking this box, you are attesting that all information provided on this form has been validated. Also, where icated on this form that you have captured "member consent" you will be able to present documentation



**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.

Re	enta	Pay	vme	nt
			, , , , , ,	

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	\$ ,
☐ Move-In Cost (e.g. moving service, moving vehicle rental)	\$ ,

#### **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 (Max \$300)	\$
☐ General Home Goods (Max \$300) (i.e. bathroom kit, kitchen, bedroom)	\$
Subtotal including taxes must not exceed \$6,000.00	\$ ,
Administrative Cost (\$60)	\$
GRAND TOTAL	\$ ,



### Please check off each box member is requesting assistance for and provide required documents.

☐ Member's Individualized Housing Support Plan that [IHSP must be included at the time of submission of this	explicitly indicates the need for Housing Deposits Services form]
☐ Security Deposits ☐ Move-in costs	<ul> <li>□ Lease with member's name, the amount for Security Deposits, and move in date</li> <li>□ Receipts do not need to be submitted to L.A. Care, but must be kept in member's records for auditing purposes</li> </ul>
☐ Utility Setup/Deposit Fees or Utility Bills	☐ Utility Bill (must include all pages and member's name must match)
☐ First/Last Month Rent Amount	$\square$ 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	<ul> <li>☐ Medi-Cal DME Denial Letter</li> <li>☐ Receipts do not need to be submitted to         <ul> <li>L.A. Care, but must be kept in members records             for auditing purposes</li> </ul> </li> </ul>
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).