



Housing Deposit Services Request for Funds Form

For the Housing Provider to Complete:

Enter date member was enrolled/opted in HN/TSS

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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:

California Medi-Cal health plan name:

- No
3. Has the assigned CS provider completed an individualized housing support plan?
 Yes
 No

 4. Has the member's assigned CS 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)

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No

If no, stop here. Member is not eligible for housing deposits.

6. Household size:

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If the member is sharing with other Partnership members, please list the name and CIN:



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Identified Needs: Check the box for each item required by the member and enter the exact cost, before tax, in the "Amount Requested" column. Once completed, sum all requested amounts and add the grand total, including any applicable tax and shipping, at the bottom of the form. The "Approved Amount" column is for internal use only. **Please note that submission does not guarantee approval of services or items.**

Rental Payment

Rental payment as required by landlord for occupancy. No allowance maximum for this section.

Service Type and Description	Amount Requested	Approved Amount
<input type="checkbox"/> Security Deposit		
<input type="checkbox"/> Move-In Cost (e.g. moving service, moving vehicle rental)		
<input type="checkbox"/> Lease Application Fees		
<input type="checkbox"/> First Month Storage		

Utilities

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

Service Type and Description	Amount Requested	Approved Amount
<input type="checkbox"/> Utility Deposit		
<input type="checkbox"/> Electricity		
<input type="checkbox"/> Heating		
<input type="checkbox"/> Gas		
<input type="checkbox"/> Water		
<input type="checkbox"/> Telephone		

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 and Description	Amount Requested	Approved Amount
<input type="checkbox"/> Fumigation		
<input type="checkbox"/> Cleaning Service		
<input type="checkbox"/> Pest Eradication		



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Medically-Necessary Adaptive Aids

If the member's durable medical equipment (DME) has been denied, submit request. Review DME policy **MCUP3013**.

Service Type and Description	Amount Requested	Approved Amount
<input type="checkbox"/> Hoyer Lift		
<input type="checkbox"/> Hospital Bed		
<input type="checkbox"/> Shower Chair		
<input type="checkbox"/> Bedside Commode		

Approved Goods

Goods designed to preserve an individual's health and safety in the home that are necessary for the individual upon move-in to the home, to ensure access and safety. **In most cases only one item is allowed, although exceptions may be made based on household size.**

Service Type and Description	Amount Requested	Approved Amount
<input type="checkbox"/> 1 Air Conditioner (Max \$150)		
<input type="checkbox"/> Bed Frame (Max \$200 per bed frame)		
<input type="checkbox"/> 1 Heater (Max \$100)		
<input type="checkbox"/> Mattress (Max \$350 per mattress)		
<input type="checkbox"/> 1 Microwave (Max \$125)		
<input type="checkbox"/> 1 Dining Table and 2 Chairs (Max \$200)		
<input type="checkbox"/> 1 Couch (Max \$200)		
<input type="checkbox"/> Infant Furniture (Max \$100)		
<input type="checkbox"/> 1 Television (Max \$150)		



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Household Items

Basic home necessities such as supplies for bathroom, kitchen, and bedroom. Household items are limited to ONE household. Please include the quantity and amounts. Receipts must be included with treatment authorization request (TAR). **Household items must be requested within 30 days of the lease move in date.**

Service Type and Description	QTY	Amount Requested	Approved Amount
<input type="checkbox"/> Kitchen Supplies (Max \$100)			
<input type="checkbox"/> Bowls	□ □		
<input type="checkbox"/> Can Opener	□ □		
<input type="checkbox"/> Cups/Glasses	□ □		
<input type="checkbox"/> Cutlery	□ □		
<input type="checkbox"/> Kitchen Utensils	□ □		
<input type="checkbox"/> Plates	□ □		
<input type="checkbox"/> Pots and Pans	□ □		
<input type="checkbox"/> Towels/Hot pads	□ □		
<input type="checkbox"/> Bedroom (Max \$50)			
<input type="checkbox"/> Bedding	□ □		
<input type="checkbox"/> Lamp/lighting	□ □		
<input type="checkbox"/> Bathroom (Max \$50)			
<input type="checkbox"/> Bathmat	□ □		
<input type="checkbox"/> Cleaning Brush	□ □		
<input type="checkbox"/> Cleaning Detergent	□ □		
<input type="checkbox"/> Plunger	□ □		
<input type="checkbox"/> Shower/Bath Curtain	□ □		
<input type="checkbox"/> Toothbrush	□ □		
<input type="checkbox"/> Other (Max \$50)			
<input type="checkbox"/> Air Filter	□ □		
<input type="checkbox"/> Night light	□ □		
<input type="checkbox"/> Trash can	□ □		
<input type="checkbox"/> Traction/Non-skid strip	□ □		
Administrative Cost (one time only (\$100))			
Total Shipping			
Total Tax			
GRAND TOTAL (Cost must not exceed \$5,000)			



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

Member's individualized housing support plan that explicitly indicates the need for housing deposits services (must be included at the time of submission of this form).

<input type="checkbox"/> Security Deposits	<input type="checkbox"/> Signed lease agreement with member's name, the amount for Security Deposits, and move in date
<input type="checkbox"/> Move-in Costs	<input type="checkbox"/> Receipts must be submitted with form
<input type="checkbox"/> Utility Setup/Deposit Fees or Utility Bills	<input type="checkbox"/> Utility Bill (must include all pages and member's name must match)
<input type="checkbox"/> Goods and Household Items	<input type="checkbox"/> Lease with member's name and the rent amount
<input type="checkbox"/> Cleaning/Pest or other service required for move-in	<input type="checkbox"/> Copy of purchase order and/or receipts must be submitted with form
<input type="checkbox"/> Medically-necessary adaptive aids and services	<input type="checkbox"/> Invoice – Service Cost
	<input type="checkbox"/> DME Denial Letter
	<input type="checkbox"/> Receipts must be submitted with form

Additional Notes and Concerns

This request does not guarantee approval of TAR. Check eligibility prior to rendering service. Payment will not be made for unauthorized services. Form with housing support plan, receipts, and other required documentation must be submitted with TAR.

By signing below, I certify that all information submitted is accurate and completed to the best of my knowledge.

Provider Signature: _____

Date: _____