Housing Deposit

CS Referral Form

Please Fax to UnitedHealthcare at 1-844-280-7080

Or send secure email to ca_cs_cm_referrals@uhc.com

Date:

Diagnosis/ICD-10 Code or eligibility qualifiers:

ID Number:

Person Making the Referral:

Organization Name:

Case Manager/Care Coordinator Name:

Phone:

Email:

Member Requesting CS:

Name:

Street Address:

City/State/Zip:

Phone:

Date of Birth:

Secondary Contact Name/Relationship:

Secondary Contact Phone/Email:

Request

Type of assistance requested (select 1 from the below categories):

☐ Security deposits required to obtain a lease on an apartment or home
☐ Set-up fees/deposits for utilities or service access and utility arrearages
☐ First month coverage of utilities, including but not limited to telephone, gas, electric, heating, water
☐ First month's and last month's rent as required by landlord for occupancy
☐ Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy

☐ Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

Amount requested: _____ Monthly Rent Amount: _____

Anticipated Move-in Date: _____ Member's Monthly Income: _____

Supporting Documentation
Attach the following documents. Absence of these documents will delay decision of this request.

Check each box of documentation provided:
☐ Homeless Assessment completed in CommunityCare
☐ Updated Individualized Housing Health Action Plan Goal available in CommunityCare
☐ Copy of lease with requested amount listed, if applicable
☐ Vendor quote, invoice, or cost estimate of service requested, if applicable
☐ Supporting documentation providing evidence that the member is not eligible for housing deposit assistance from other state, local, or federally funded programs. If unable to obtain documentation, please include a detailed progress note to be entered below regarding what community resources were explored to identify alternate funding prior to submission of this request including CIE submission.

CS Eligibility
Has the member ever received Housing Deposit Assistance from United Healthcare Community Plan before? Choose an item.

If yes, please provide documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Click or tap here to enter text.

Describe what attempts have been made to secure this type of assistance from other state, local, or federally funded programs, which should always be considered first before using Medi-Cal funding. Please provide additional details about the type of support and expected duration of the support the member will receive in addition to this request. *Please include supporting documentation in the attachments*
Click or tap here to enter text.

Independent Sustainability

1. Will the member be able to financially sustain the housing after move-in? **Yes / No**
2. Is the member currently receiving Housing Transition/Navigation CS? **Yes / No**
3. Will the member receive Tenancy Support CS after they obtain housing? **Yes / No**