Santa Clara Family Health Plan

# Community Supports (CS) Referral Form

Housing Services

Email: CS@scfhp.com

Fax: **1-408-874-1985**

Return completed referral form and all applicable documentation via SECURE email to CS@scfhp.com or fax to **1-408-874-1985**. Allow up to 5 business days for referral to be reviewed once received. Referal forms can also be completed and submitted via the SCFHP Provider Portal. Questions? Please call our Community Supports direct line at 1-408-874-1929.

- Community Supports are medically appropriate and cost-effective alternatives to services covered under Medi-Cal, such as hospital care, nursing facility care, and emergency department (ED) utilization. Community Supports are optional services for Medi-Cal managed care plans to provide and are optional for managed care members to use. These services will vary based on enrollee needs and care plan goals.
- Housing Services Community Supports are available to members that meet the following criteria. Options may have different requirements. Please ensure member meets all criteria before submitting this referral form.
- Santa Clara Family Health Plan (SCFHP) may require additional documentation to ensure members meet criteria.
- Members may be enrolled in more than one Community Supports at a time, however they cannot exceed lifetime maximums.
- Referal forms can also be completed and submitted via the SCFHP Provider Portal.

| **Patient/Member Information** | |
|---|---|
| First Name: | Last Name: |
| DOB: | SCFHP ID: |
| Phone: | Authorized Representative: |
| Today's Date: | |
| | |
| **Name/Agency Referral Information** | |
| Referral Source: | |
| Agency *(if applicable)*: | Agency Phone: |
| Is referring agency a SCFHP ECM Provider? ☐ Yes or ☐ No | |

| **Which Housing Service should the member receive?** *Please note, members may only receive one of option.* |
|---|
| ☐ Housing Tranistion/Navagational Services |
| ☐ Housing Deposits |

**Eligibility Survey**

| Initial Community Supports Criteria: | Yes | No |
|---|---|---|
| 1. Does the member meet criteria for permanent supportive housing through the homeless Coordinated Entry System and are they prioritized to receive permanent supportive housing? (Refer to the Homeless Management Information System (HMIS) to verify.) | ☐ | ☐ |
| 2. Member received Housing Transition/Navigation Services Community Supports | ☐ | ☐ |

- If the answer to question #1 is **yes,** the member is elligible for Housing Transition/Navigation Services. Proceed to Member Consent section.
- If the answer to question #1 and #2 were **yes,** the member is eligible for Housing Deposits. Proceed to Member consent section.
- If the answer is **no**, please proceed with the survey.

| | Secondary Level Criteria<br>Does the member fall into the criteria listed below? | Yes | No |
|---|---|---|---|
| 1 | Enrolled in SCFHP's Enhanced Care Management (ECM) and meets U.S. Department of Housing and Urban Development (HUD) definition of Homeless (*CFR 24, Section 91.5) including those discharging from an institution, but not including limits on days **to determine if member meets this criteria, complete D1* | ☐ | ☐ |
| 2 | Meets HUD definition of Homeless including those discharging from an institution, but not including limits on days **to determine if member meets this criteria, complete D1*<br>**AND**<br>Diagnosed with 1 or more serious Chronic condition or serious mental illness and/or are at risk for institutionalization or needs residential services for substance use disorder | ☐ | ☐ |
| 3 | Meets HUD definition of Homeless including those discharging from an institution, but not including limits on days **to determine if member meets this criteria, complete D1*<br>**AND**<br>Diagnosed with a serious Mental Illness | ☐ | ☐ |
| 4 | Meets HUD definition of Homeless including those discharging from an institution, but not including limits on days **to determine if member meets this criteria, complete D1*<br>**AND**<br>At risk of institutionalization or requiring residential services as a result of a substance use disorder | ☐ | ☐ |

- If the answer yes to 1, 3, or 4, proceed to Member Consent. Otherwise please continue with the survey
- If the answer yes to all the criteria or the following combinations, proceed to Member Consent. Otherwise please continue with the survey
    - 2 and 3
    - 2 and 4
    - 2, 3, and 4
- If you are referring a member for Housing Deposits please proceed to Member Consent.

| **Third Level Criteria for Housing Transition/Navigation Services Only**<br>At Risk of Homelessness status by population (must meet at least 1 definition) | | | |
|---|---|---|---|
| Individual or Family | | **Yes** | **No** |
| 1 | Meets the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations<br>*To determine if member meets this criteria, complete D2* | ☐ | ☐ |
| Child or Youth | | | |
| 2 | A child or youth who does not qualify as "homeless" under the Runaway and Homeless Youth Act - section 387(3), Head Start Act section - section 637(11), Violence Against Women Act of 1994 (section 41403(6), Public Health Service Act- section 330(h)(5)(A), Food and Nutrition Act of 2008 - section 3(m), Child Nutrition Act of 1966 - section 17(b)(15). | ☐ | ☐ |
| 3 | A child or youth who does not qualify as "homeless" under previous sections, but qualifies as "homeless" under McKinney-Vento Homeless Assistance Act - section 725(2)<br>**AND**<br>the parent(s) or guardian(s) of that child or youth if living with her or him | ☐ | ☐ |
| 4 | Individuals who have been determined to be at risk of experiencing Homelessness and has Significant barriers to stable housing—*If member is experiencing any of the following and has been determined to be at risk of experiencing Homelessness, Select Yes* | ☐ | ☐ |
| | Have 1+ serious chronic condition | ☐ | ☐ |
| | Serious Mental Illness | ☐ | ☐ |
| | At risk of institutionalizations/overdoes/requires residential services due to Substance use Disorder | ☐ | ☐ |
| | Serious Emotional Disturbance (Children & Adolescents) | ☐ | ☐ |
| | Receiving ECM | ☐ | ☐ |
| | Transition-Age youth with significant barriers to housing stability: (one+ convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, have a serious mental illness, have been victims of trafficking) | ☐ | ☐ |

**Please proceed to Member Consent section.**

| D1 | **U.S. Department of Housing and Urban Development- HUD (CFR 24, Section 91.5)** | **Yes** | **No** |
|---|---|---|---|
| Individuals or Families must meet one of the following criteria: *(Must meet #1 or #2 in **Bold** to meet criteria)* | | | |
| 1. | **Lacks fixed, regular, and/or adequate nighttime residence** (Choose Yes if at least one of the following are true) | ☐ | ☐ |
| | Nighttime residence is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (car, park, abandoned building, bus or train station, airport, or camp ground) | | |

| | | | |
|---|---|---|---|
| | living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals) | | |
| | exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution | | |
| 2. | **Will imminently lose their primary nighttime residency provided that one of the following are true:** | ☐ | ☐ |
| | Will imminently lose their primary nighttime residents in the next 14 days | | |
| | No subsequent residence have been identified | | |
| | Lacks resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing | | |

Unaccompanied youth under 25 and/or Families with children & youth: *(Must meet criteria for at least one of the following #1-5)*

| | | | |
|---|---|---|---|
| 1. | **Meet the definition of homeless under at least 1 of the following:** | ☐ | ☐ |
| | Runaway & Homeless Youth Act 42 U.S.C 2732a- Section 387 | | |
| | Head Start Act42 U.S.C. 9832- Section 637 | | |
| | Violence Against Women Act 42 U.S.C 14043E-2 | | |
| | Public Health Service Act 42 U.S.C. 254b(h)-Section 330 (h) | | |
| | Food and Nutrition act of 2008 7 U.S.C. 2012- Section 3 | | |
| | Child Nutrition Act of 1966 42 U.S.C. 1786(b)- Section 17 (b) | | |
| | McKinney-Vento Homeless Assistance Act 42 U.S.C. 11434a- Section 725 | | |
| 2. | **No lease, ownership interest, or occupancy agreement for permanent housing during the last 60 days** | ☐ | ☐ |
| 3. | **Has experienced persistent instability- 2+ moves in the last 60 days** | ☐ | ☐ |
| 4. | **Housing status is not expected to change due to *(one of the following a-e OR 2+ more employment barriers f-j)*** | ☐ | ☐ |
| | a. chronic disabilities | | |
| | b. chronic physical health or mental health conditions | | |
| | c. substance addiction | | |
| | d. history of domestic violence or childhood abuse (including neglect) | | |
| | e. the presence of a child or youth with a disability | | |
| 5. | **Housing status is not expected to change due to *(Two or more barriers to employment f-j)*** | ☐ | ☐ |
| | f. lack of a high school degree or General Education Development (GED) | | |
| | g. illiteracy | | |

| | | | |
|---|---|---|---|
| | h. low English proficiency | | |
| | i. history of incarceration or detention for criminal activity | | |
| | j. history of unstable employment | | |
| Special Circumstances—All populations | | | |
| 1. | **Fleeing/attempting to flee any dangerous or life-threatening condition related to violence against the individual or family** | ☐ | ☐ |
| 2. | **Has no other residence** | ☐ | ☐ |
| 3. | **Lacks the resources or support networks to obtain other permanent housing** *(e.g. family, friends, faith base or other social networks)* | ☐ | ☐ |

| D2 | **At Risk of Homelessness-** HUD (CFR 24, Section 91.5) | **Yes** | **No** |
|---|---|---|---|
| | Individuals or Families must meet one of the following criteria: *(Must meet the annual income and one other definition #2-6 )* If the answer to questions #1 is "Yes" and one other definition Member is at risk of Homelessness—Select "Yes" in the Third Level Criteria for Housing Transition/Navigation question #1. | | |
| 1 | Has an annual income below 30 percent of median family income for the area, as determined by HUD (see guideline for 2021 here)[1] | ☐ | ☐ |
| 2 | Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter<br>**AND**<br>has moved due to economic reasons 2+ times during the 60 days prior to application for homelessness prevention assistance;<br>**OR**<br>is living in someone else home due to economic hardship;<br>**OR**<br>has been notified in writing of termination of occupancy within the next 21 days *of support networks, e.g. family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter* | ☐ | ☐ |
| 3 | Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter<br>**AND**<br>lives in a hotel/motel that is not being paid by a charitable organization, federal, state or local government programs | ☐ | ☐ |
| 4 | Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter<br>**AND**<br>lives in a single room occupancy or efficiency unit where 2 or more Persons reside.<br>**OR**<br>Living in a larger housing unit in which there is more than 1.5 people per room residing. | ☐ | ☐ |

[1] https://bit.ly/3eFnLKB

| | | | |
|---|---|---|---|
| 5 | Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter **AND** exiting a publicly funded institution or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution) | ☐ | ☐ |
| 6 | Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter **AND** otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan | ☐ | ☐ |

**Member Consent**

Member consent must be obtained prior to providing any Community Supports service. The member has the right to retract consent at any time.

Select the form or consent received from the member

*Note if written consent was obtained please provide a copy with this request*

☐ Verbal Consent *(member/AOR)* ☐ Written Consent *(member/AOR)* ☐ No Consent

| **Data Sharing**: *The following information is **required** to ensure member will be assigned to the appropriate provider. Please answer all question to the best of your ability.* | **Yes** | **No** |
|---|---|---|
| Has the member being referred, been hospitalized in the last 6 months? | ☐ | ☐ |
| Has the member being referred, been admitted to a Skilled Nursing Facility in the past 6 months? | ☐ | ☐ |
| Has the member being referred, been diagnosed with any of the following chronic conditions?<br>☐Diabetes ☐ Hypertension ☐CHF ☐Renal Disease ☐Cardiovascular Disease ☐Cancer ☐ Stroke☐<br>Human Immunodeficiency Virus (HIV) ☐ Gestational Diabetes ☐ High Risk Perinatal Conditions | | |
| Has the member being referred, ben diagnosed with any of the following mental/behavioral Health conditions (select all conditions that apply)?<br>☐Depression ☐Anxiety ☐Bipolar ☐Schizophrenia ☐Schizoaffective Disorder ☐Substance Use Disorder<br>☐Serious Mental Illness/Serious emotional disturbance | | |
| Is member enrolled in Enhanced Case Management (ECM) | ☐ | ☐ |
| If answer to question above is YES, who is their ECM Provider? | | |

**Additional Information**

Individuals should not be receiving duplicative support from other State or local tax or federally funded programs. SCFHP is the payer of last resort for Community Supports services.

1. Has member been enrolled in and/or received services for any of the following programs in the last 3 months?

A. Move-in and deposit assistance from:

☐Community Services Agency of Mountain View & Los Altos ☐LifeMoves Georgia Travis House

☐LiveMoves Opprotunity Center ☐Sunnyvale Community Services ☐Salvation Army

☐Sacred Heart Community Services ☐St. Joseph's Family Center ☐West Valley Community Services

☐Project Sentinel ☐HOMEFIRST ☐Inn Vision ☐United Way Silicon Valley

☐San Jose St. Vincent de Paul Society ☐San Jose First Community Services Inc.

☐Silicon Valley Independent Living Center- CCT program

B. Housing Navigation Services from:

☐Community Services Agency of Mountain View & Los Altos ☐LifeMoves Georgia Travis House

☐LiveMoves Opprotunity Center ☐Sunnyvale Community Services ☐Salvation Army

☐Sacred Heart Community Services ☐St. Joseph's Family Center ☐West Valley Community Services

☐Project Sentinel ☐HOMEFIRST ☐Inn Vision ☐United Way Silicon Valley

☐San Jose St. Vincent de Paul Society ☐San Jose First Community Services Inc.

☐Silicon Valley Independent Living Center- CCT program

2. Has member received any other financial assistance from a Community Based Organization and/or State, County, City agency in the past 3 months? ☐ Yes ☐ No

**Attestation of Completeness and Accuracy of Information Provided**

By signing below, I am attesting that all information provided is complete and correct to the best of my knowledge.

| | |
|---|---|
| | |
| Printed Name | Title |
| | |
| Signature | Date |