Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

# COMMUNITY SUPPORTS (CS) REFERRAL FORM

Please send the completed form to either calaim@goldchp.org or fax it to **1-855-883-1552**.

## MEMBER INFORMATION

*Please print or type*

Last Name: _____ First Name: _____ Date: _____

Mailing Address: _____ City: _____ Zip: _____

Medi-Cal ID: _____ Phone: _____ Birth Date: _____

Language Preference: ☐ English ☐ Spanish ☐ Other: _____

## REFERRAL SOURCE INFORMATION

Last Name: _____ First Name: _____

Mailing Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

**RELATION TO MEMBER:** ☐ Self ☐ Parent / Guardian ☐ Family / Friend ☐ Primary Care Provider (PCP)
☐ Enhanced Care Management (ECM) Provider ☐ Other Service Provider ☐ GCHP Staff ☐ Community Based Organization (CBO)

**PREFERRED CONTACT METHOD:** ☐ Email ☐ Phone ☐ Mail

**REFERRING ORGANIZATION** (if applicable):

**HAS THE MEMBER BEEN INFORMED THAT A REFERRAL WAS BEING SUBMITTED?** ☐ Yes ☐ No

**COMMENTS:**

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| REASON FOR REFERRAL *(check all that apply)* | | |
|---|---|---|
| **Community Support** | **What is it?** | **Who is eligible?** |
| ☐ Medically Supportive Food | Meals designed for specific medical needs or for recovery following hospitalization. | For members whose health could benefit from short-term meals tailored to their needs based on identified chronic conditions. |
| ☐ Housing Transition Navigation | Help with finding and getting housing, including help with housing applications. | Members who are homeless or at risk of homelessness and at least one of the following:<br>• Have one or more serious chronic conditions<br>• Serious mental illness / substance use disorder<br>• At risk of institutionalization<br>• Serious emotional disturbance (children / adolescents)<br>• Exiting incarceration OR<br>• Transitional-aged youth with significant barriers to housing |
| ☐ Housing Deposits<br>* Must be receiving Housing Transition Navigation Services. | Funding for one-time services necessary to establish a household, including security deposits, first month's utilities, equipment needed for a health condition, or first and last month's rent. | |
| ☐ Housing Tenancy and Sustaining Services | Help with keeping housing, including help with managing money and good tenant behaviors. | |

| REFERRAL ELIGIBILITY | | |
|---|---|---|
| 1. Does the client have at least one chronic medical condition? | ☐ Yes ☐ No | If Yes, go to question 2,<br>If No, **not eligible for CS referral** |
| 2. Is the client currently homeless? | ☐ Yes ☐ No | If Yes, go to question 4,<br>If No, go to question 3. |
| 3. Is the client at risk of homelessness? (Eviction notice has been provided) | ☐ Yes ☐ No | If Yes, go to question 4,<br>If No, **not eligible for CS referral** |
| 4. Is the client receiving Housing Navigation from any other agency? | ☐ Yes ☐ No | If Yes, **not eligible for CS referral,**<br>If No, **is eligible for CS referral** |

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| REFERRAL PURPOSE |
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