Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

COMMUNITY SUPPORTS (CS)
HOUSING SUITE AUTHORIZATION REQUEST FORM

☐ Initial Request ☐ Reauthorization ☐ Urgent (72 hours) ☐ Routine ☐ Retroactive

FAX: 1-855-883-1552 PHONE: 1-888-301-1228 www.goldcoasthealthplan.org

PROVIDER INFORMATION

Referring (Ordering) Provider

Name: _____

Specialty: _____

NPI: _____ TIN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

Servicing CS Provider

☐ Same as Referring (Ordering) Provider

Name: _____

Specialty: _____

NPI: _____ TIN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Mailing Address: _____ City: _____ Zip: _____ *(Required)*

Medi-Cal ID: _____ *(Required)* Phone: _____ Birth Date: _____ *(Required)* Age: _____

Name of PCP: _____ Location: _____

Members receiving similar services through other community and government programs are ineligible to receive GCHP Community Supports concurrently.

HOUSING SUITE OF SERVICES AUTHORIZATION REQUEST

Diagnosis: _____ **ICD-10**: _____

☐ Housing Tenancy and Sustaining

Date of Service: _____ HCPCS Code: _____ Modifier: _____ Quantity: _____

Date of Service: _____ HCPCS Code: _____ Modifier: _____ Quantity: _____

☐ Housing Transition Navigation

Date of Service: _____ HCPCS Code: _____ Modifier: _____ Quantity: _____

Date of Service: _____ HCPCS Code: _____ Modifier: _____ Quantity: _____

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☐ **Transitional Rent** *Member must be receiving Transition Navigation Services from the same provider.*	
Date of Service: _____ HCPCS Code: _____ Modifier: _____ Quantity: _____	
Documents to submit with request:	☐ Referral form (if applicable)
☐ **Housing Deposit** *Member must be receiving Transition Navigation Services from the same provider.*	
Date of Service: _____ HCPCS Code: _____ Modifier: _____ Quantity: _____	
Documents to submit with request:	☐ Referral form (if applicable)

COMMUNITY SUPPORTS HOUSING SUITE ELIGIBILITY CRITERIA	
Homeless	☐ Unhoused or at imminent risk of becoming homeless (housing insecure) (as defined below; check all that apply) ☐ An individual who lacks adequate nighttime residence. ☐ An individual or family with a primary residence that is a public or private space not designed for or ordinarily used for human habitation. ☐ An individual or family living in a shelter. ☐ An individual exiting an institution to homelessness (if exiting an institution, individuals are considered homeless if they were unhoused immediately prior to entering that institutional stay, regardless of the length of institutionalization). ☐ An individual or family who will imminently lose housing in the next 30 days (housing insecure). ☐ Unaccompanied youth and families experiencing homelessness and children and youth defined as homeless under other federal statutes. ☐ Victims fleeing domestic violence.
And at least one of the following:	☐ One or more serious chronic conditions ☐ Serious mental illness / substance use disorder ☐ At risk of institutionalization ☐ Serious emotional disturbance (children / adolescents) ☐ Exiting incarceration ☐ Transitional-aged youth with significant barriers to housing