KAISER PERMANENTE®

Community Supports – Referral Form
Housing Insecurities

Kaiser Permanente **ONLY** accepts referrals for **Medi-Cal Members** whose coverage is assigned to Kaiser Permanente.

Kaiser Permanente employs a “No Wrong Door” approach for Community Supports referrals – referrals will be accepted from all points of care within the continuum.

What are Community Support services?

Community Supports (CS) are non-medical services (e.g., housing navigation, asthma remediation) provided as cost-effective alternatives to traditional medical services and settings. CS availability varies by county.

Which Community Supports does this referral form cover?

This referral form is for the CS services aimed to support Housing Insecurity, which includes:

The Housing Trio

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services

And

4. Day Habilitation Programs
5. Recuperative Care (Medical Respite)
6. Short-Term Post-Hospitalization Housing

Instructions

Fill out this form and all required fields to the best of your ability. Submit this form to the appropriate region via secure email. Missing information may result in additional processing delays.

- Northern California referrals REGMCDURNs-KPNC@KP.org
- Southern California referrals RegCareCoordCaseMgmt@KP.org

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SECTION A

Fields marked with an asterisk (*) are mandatory

Is the person being referred a Kaiser Permanente (KP) Medi-Cal Member?*

☐ Yes, this is a Kaiser Permanente Medi-Cal Member

☐ No. STOP, do NOT proceed. Please send referral to their assigned Medi-Cal Managed Care Plan.

Referral Source Information

Date of Referral*

Referrer Name*

Referrer Organization Name*

Referrer Email*

Referrer Phone Number*

Referrer Relationship to Member*

External referral by, select ONE*

☐ Network Lead Entity (NLE)

☐ ECM/CS Vendor (please indicate which NLE you are affiliated with)

☐ Full Circle Health ☐ Independent Living Systems ☐ Mom's Meals ☐ Partners in Care

☐ Managed Care Plan (MCP)

☐ Other health care provider

☐ Mental health care provider

☐ Hospital or ER care team

☐ County or other government organization

☐ Schools/Local Education Agency (LEAs)

☐ Other community-based provider

☐ Legal aid organizations

☐ Justice involved organizations

☐ Other:

Attestation

☐ By checking this box, you confirm that all information provided on this form is accurate and has been verified. You also confirm that the Member has consented to participating in the program(s) they are being referred to AND that you can provide supporting documentation if requested.

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SECTION A

Fields marked with an asterisk (*) are mandatory

Member Information

Member Name*

Member Date of Birth* | **Member Phone Number***

Member Mailing Address* (Street, City, State, Zip Code)

Member's Kaiser Permanente MRN* (if known) | **Member's Medi-Cal CIN** (if known)

Caregiver/Support Person Name

Caregiver/Support Person Contact (Email/Phone Number)

Current Service Usage

Is the Member currently receiving any of the following services? Check ALL that apply:

☐ **Enhanced Care Management**

Provider Name:

Provider Email/Phone Number:

☐ **Complex Case Management**

☐ **Community Health Worker**

Community Supports

☐ Housing Transition Navigation Services
☐ Housing Deposits
☐ Housing Tenancy and Sustaining Services
☐ Day Habilitation Programs
☐ Recuperative Care (Medical Respite)
☐ Short-Term Post-Hospitalization Housing
☐ Respite Services (Caregiver Respite)
☐ Assisted Living Facility Transitions
☐ Community or Home Transition Services
☐ Personal Care and Homemaker Services
☐ Environmental Accessibility Adaptations (Home Modifications)
☐ Medically Tailored Meals/Medically-Supportive Food
☐ Sobering Centers
☐ Asthma Remediation

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SECTION B

☐ 1. Housing Transition Navigation

Important Information – Please Read

- **Description:** Provides Members with housing insecurity to receive assistance to find, apply for, and secure housing.
- A Member cannot be enrolled in Housing Transition Navigation and Housing Tenancy and Sustaining Services at the same time. Please **ONLY** select **ONE** service.

1.1) To be eligible, the Member MUST meet ONE of the following criteria. Select the ONE that applies:

☐ Prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System

OR

☐ Meet the HUD definition of homelessness; **AND** one of the following criteria below. Select the **ONE** that applies:

- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has serious mental illness
- ☐ **D.)** Is at risk of institutionalization
- ☐ **E.)** Is requiring residential services as a result of substance use disorder

OR

☐ Member meets the HUD definition of at risk of homelessness; **AND** one of the following criteria below. Select the **ONE** that applies:

- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has a Serious Mental Illness
- ☐ **D.)** Is at risk of institutionalization or overdose
- ☐ **E.)** Is requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents)
- ☐ **F.)** Is a Transition-Age Youth with significant barriers to housing stability

Comments (optional)

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SECTION B

☐ 2. Housing Deposits

Important Information – Please Read

- **Description:** Assist Members with housing insecurity to cover one-time expenses to facilitate transition into newly secured housing.
- This is a once-in-a-lifetime service with a maximum of $5,000.

2.1) Is the Member currently receiving Housing Transition Navigation?

☐ Yes

☐ No ***If no, please refer the Member to Housing Transition Navigation Services**

2.2) The Member is receiving Housing Transition Navigation services AND meets ONE of the following criteria. Select the ONE that applies:

☐ Prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System

OR

☐ Meet the HUD definition of homelessness; **AND ONE** of the following criteria below. **Select the ONE that applies:**

- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has serious mental illness
- ☐ **D.)** Is at risk of institutionalization
- ☐ **E.)** Is requiring residential services as a result of substance use disorder

2.3) Which of the following one-time expenses is the Member requesting? Select ALL items that apply:
List the estimated cost next to the one-time expenses e.g., Application fee $50, Security deposit $1800.

☐ **Application fee:**

☐ **Security deposit:**

☐ **First and last month's rent:**

☐ **Set up fees/deposits or first month's coverage for utilities or service access:**

☐ **Services necessary for the individual's health and safety:**

☐ **Home goods:**

SECTION B

☐ 2. Housing Deposits (Continued)

2.4) What home goods is the Member requesting? Select ALL items that apply:
List the item and the estimated cost next to the home goods e.g., Bedding $100, mattress $200

☐ **Kitchen:** bowls, cutlery, dish towels, pots and pans, sponges, dishwasher, cups/glasses, cutting boards, utensils, refrigerator, soap, oven, can opener, dining table/chairs, microwave, stove, placemats, cleaning supplies, dish drying rack, plates, place setting, salt/pepper shakers

Item/Estimated cost:

☐ **Bedroom:** bedframe, mattress, bedding, clothes hangers, infant furniture, nightstand, hypoallergenic mattress cover, pillow covers

Item/Estimated cost:

☐ **Bathroom:** bathmat, soap dish, shower/bath curtains, toiletries, towels, trash can, toothbrush holder, cleaning supplies

Item/Estimated cost:

☐ **Living Room:** couch, lamps/lighting, coffee/end tables

Item/Estimated cost:

☐ **Other:** Air conditioners, air filters, heater, cleaning supplies, medically necessary adaptive aids, night lights, vacuum cleaner, smoke detectors, carbon monoxide detectors

Item/Estimated cost:

2.5) What is the total requested amount for housing deposits:

Comments (optional)

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SECTION B

☐ 2. Housing Deposits (Continued)

Required documents for ALL services:
☐ Recent proof of income to support monthly rent and living expenses *(1 month for consistent income and up to 3 months for inconsistent income)*

☐ Member's individualized housing support plan Including a financial sustainability plan (i.e. Member's income, rent amount, breakdown of monthly expenses, and details of what the Member needs)

Services	Supporting documents to be collected by NLE
☐ Application fee ONLY request *(no backdate)*	☐ Copy of filled out application with application fee noted ***Authorization amount: $300 maximum per Member***
☐ Security deposit *(30 days from the Member's move-in date)* ☐ First and last month's rent required by the landlord for occupancy *(30 days from the Member's move-in date)*	☐ Lease Agreement with the Member's name, amount for security deposit and move-in date
☐ Set up fees/deposits for utilities or services access and one-month payment in utility arrear *(30 days from the Member's move-in date)* ☐ First-month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water *(30 days from the Member's move-in date)*	☐ Utility bill (must include all pages and the Member's name must match)
☐ Services necessary for the Member's health and safety *(no backdate)*	☐ Rationale and quote of service cost
☐ Household items and furnishings needed to establish community-based tenancy *(30 days from the Member's move-in date)*	☐ Pre-purchase: Itemized breakdown of costs ***Itemized lists and receipts must be kept in the Member's record for auditing purposes***

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SECTION B

☐ 3. Housing Tenancy and Sustaining Services

Important Information – Please Read

- **Description:** Supports Members with housing insecurity to maintain safe/stable tenancy in secured housing. This is a once-in-a-lifetime service.
- A Member cannot be enrolled in Housing Transition Navigation and Housing Tenancy and Sustaining Services at the same time. Please **ONLY** select **ONE** service.

3.1) To be eligible, the Member MUST meet ONE of the following criteria. Select the ONE that applies:

☐ Member is receiving Housing Transition/Navigation Services Community Support

OR

☐ Member is prioritized for a permanent supportive housing unit or rental subsidy

OR

☐ Member meets the HUD definition of homelessness; **AND ONE** of the following criteria below. **Select the ONE that applies:**

- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has serious mental illness
- ☐ **D.)** Is at risk of institutionalization
- ☐ **E.)** Is requiring residential services as a result of substance use disorder

OR

☐ Member meets the HUD definition of at risk of homelessness; **AND ONE** of the following criteria below. **Select the ONE that applies:**

- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has a Serious Mental Illness
- ☐ **D.)** Is at risk of institutionalization or overdose
- ☐ **E.)** Is requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents)
- ☐ **F.)** Is a Transition-Age Youth with significant barriers to housing stability

3.2) Member move-in date:

Comments (optional)

SECTION B

☐ 4. Day Habilitation Programs

Important Information – Please Read

- **Description:** Assists Members with housing insecurity to develop life skills necessary to reside in natural environment.
- While receiving Day Habilitation Program services, Members needing assistance with housing-related services and supports should be referred for the Housing Trio.

4.1) The Member MUST meet ONE of the following criteria. Select the ONE that applies:

☐ Member is experiencing homelessness

OR

☐ Member exited homelessness (no longer homeless) and entered housing in the last 24 months

OR

☐ Member at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program

4.2) What type of trainings is the Member interested in receiving? Select ALL that apply:

☐ The use of public transportation

☐ Personal skills development in conflict resolution

☐ Community participation

☐ Developing and maintaining interpersonal relationships

☐ Daily living skills (cooking, cleaning, shopping, money management)

☐ Community resource awareness such as police, fire, or local services to support independence in the community

4.3) Which assistance programs is the Member interested in receiving? Select ALL that apply:

☐ Selecting and moving into a home

☐ Locating and choosing suitable housemates

☐ Locating household furnishings

☐ Settling disputes with landlords

☐ Managing personal financial affairs

☐ Refer to the Housing Transition/Navigation Services CS

☐ Refer to the Housing Tenancy and Sustaining Services CS

☐ Referral to non-CS housing resources if Member does NOT meet Housing Transition/ Navigation Services eligibility criteria

☐ Recruiting, screening, hiring, training, supervising, and dismissing personal attendants

☐ Dealing with and responding appropriately to governmental agencies and personnel

☐ Asserting civil and statutory rights through self-advocacy

☐ Building and maintaining interpersonal relationships, including a circle of support

☐ Coordination with CS and/or ECM services for which the Member may be eligible

☐ Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if Member is NOT receiving these services through CS or ECM

SECTION B

☐ 4. Day Habilitation Programs (Continued)

Comments (optional)

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SECTION B

☐ 5. Recuperative Care (Medical Respite)

Important Information – Please Read

- **Description:** Assists Members with housing insecurity to receive short-term shelter while recovering from illness/injury.
- Includes limited or short-term assistance with instrumental Activities of Daily Living (ADLs) to the extent permitted by licensure.
- While receiving Recuperative Care services, Members should be offered Housing Transition/Navigation services.
- For Recuperative Care, the Member will need to be placed in a Kaiser Permanente contracted facility prior to submitting the referral (this form).
- Recuperative care cannot exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.

5.1) Is this a Streamlined Authorization request? *(Question 5.1 - To be completed by the Network Lead Entities or Recuperative Care Facility)*

☐ Yes ☐ No

Facility Name:

Service Start Date:

5.2) To be eligible, the Member MUST meet BOTH of the following criteria:

☐ Member requires recovery in order to heal from an injury or illness

AND

☐ Member is experiencing or is at risk of homelessness

Comments (optional)

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SECTION B

☐ 6. Short-Term Post-Hospitalization Housing

Important Information – Please Read

- **Description:** Provides post-hospitalization housing to Members with housing insecurity and high health needs.
- While receiving Short Term Post Hospitalization Housing, Members should be offered Housing Transition/Navigation services.
- Short-Term Post Hospitalization Housing cannot exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.

6.1) The Member MUST meet ALL of the following criteria:

☐ Member is exiting an institution, which includes recuperative care facilities, inpatient hospitals, residential substance use disorder or mental health treatment facility, correctional facility, or nursing facility

AND

☐ Member is experiencing or is at risk of homelessness

AND

Member meets one of the following criteria below. **Select the ONE that applies:**

- ☐ **A.)** Is receiving Enhanced Care Management
- ☐ **B.)** Has one or more serious chronic conditions
- ☐ **C.)** Has a serious mental illness
- ☐ **D.)** Is at risk of institutionalization or requiring residential services as a result of substance use disorder

AND

☐ Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post Hospitalization Housing

6.2) Facility Information:

Facility Name:

Facility Type:

Expected Discharge Date:

Comments (optional)

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STOP!
PLEASE BE SURE TO:

Fill out this form and all required fields to the best of your ability. Submit this form to the appropriate region via secure email. Missing information may result in additional processing delays.

- Northern California referrals REGMCDURNs-KPNC@KP.org
- Southern California referrals RegCareCoordCaseMgmt@KP.org