



**CS Housing Deposits  
All Counties**

**Housing Deposits Community Supports (CS) assists members experiencing homelessness with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute rent.**

**Members must be receiving Housing Transition Navigation services. Please note that Housing Deposits must be reasonable and necessary, in the member’s Individualized Housing Support Plan, and are available only because the member is unable to meet such expense.**

Send completed referral via secure email: MHC\_CS@MolinaHealthcare.com or fax to: (833) 908-4424.

<b>Eligibility Criteria:</b>
Molina Enrollment: <input type="checkbox"/> Only Medi-Cal <input type="checkbox"/> Partial Duals Only: Medi-Cal with Medicare Part B and/or D
<b>Member must meet one of the three (3) following criteria:</b>
<input type="checkbox"/> Member is currently receiving or has received Housing Transition Navigation services. <input type="checkbox"/> Member is prioritized for permanent supportive housing unit or rental subsidy through CES or similar system. <input type="checkbox"/> Member meets the HUD definition of homelessness AND one of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Enrolled in ECM.</li> <li><input type="checkbox"/> Have a serious chronic condition, or serious mental illness.</li> <li><input type="checkbox"/> At risk for institutionalization or require residential services as a result of SUD.</li> </ul>
<input type="checkbox"/> The Individualized Housing Support Plan is attached which showcases the documented needs.
Organization who helped develop the Housing Support Plan:
<input type="checkbox"/> Member consented to Housing Deposits referral and acknowledges the once in a lifetime restriction.

<b>Requestor Information:</b>	
Last Member Contact:	Housing ETA Date:
Referrer: <input type="checkbox"/> Housing Transition Navigation CM <input type="checkbox"/> Other:	
Referrer Organization Name:	
Referrer Name:	Title:
Referrer Phone Number:	Fax Number:

<b>Member Information:</b>	
Member Name:	DOB:
Medi-Cal ID:	Preferred Language:
Current Living Situation:	
Cell Phone Number:	
Alternate Contact Name:	Phone #:

If member has previously received Housing Deposits Community Supports services, please include information explaining what conditions have changed to demonstrate why the second attempt would be more successful.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.