Homeless and Housing Support Services Program (HHSS) Form

SCAN Housing and Homeless Case Management Team provides two services to eligible members: housing navigation and tenancy services. To submit a referral or an extension request, all required fields in this form must be completely filled out and submitted via Secure Email (**CMReferral@scanhealthplan.com**). This form is only for SCAN Members enrolled in a Connections ABD or Connections at Home plan, residing in LA County.

Please check the type of service the member is requesting:

1. ☐ Housing Transition Navigation Services – Assistance finding & applying for stable housing
   ☐Initial Request ☐Extension Request
2. Tenancy & Sustaining Services – Ongoing support to maintaining housing
   ☐Initial Request ☐Extension Request

Referral Source Information

Date of Referral:* _____

External referral by* (select one): ☐ECM provider ☐Homeless Provider ☐Hospital ☐PCP/Clinic ☐MG ☐Other:_____

Referring Individual Name:* _____

Referring Organization Name:* _____

Referrer Phone Number:* ( ) _____

Referrer Email Address:* _____

Is member aware of referral? ☐ Yes ☐ No

Member Information

First Name:* _____ Last Name:* _____

Medi-Cal Client ID# (CIN):* _____ Member ID: _____

Preferred Language:* _____ Date of Birth:* _____

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other _____

Mailing address or location:* _____

If member is moving into new address, please include new address.

_____

Primary Phone Number:* ( ) _____ Best Time to Contact:* _____

Authorized Representative Name: _____ Phone Number:* ( ) _____

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Member Housing Status Information

Is member homeless?* ☐ Yes ☐ No ☐ Unknown

If no, is member at risk of homelessness ☐ Yes ☐ No ☐ Unknown

If member is NOT currently homeless, was the member previously homeless? ☐ Yes ☐ No ☐ Unknown

Current Living Location:* ☐ Interim Housing ☐ Other Housing ☐ Permanent Supportive Housing ☐ Shelter
☐ Skilled Nursing Facility / Long Term Care ☐ Street ☐ Unknown ☐ Other_____
Address for current living location:* _____

Current SPA location:*

☐ SPA 1: Antelope Valley
☐ SPA 2: San Fernando Valley
☐ SPA 3: San Gabriel Valley
☐ SPA 4: Metro LA
☐ SPA 5: West
☐ SPA 6: South
☐ SPA 7: East
☐ SPA 8: South Bay
☐ Unknown

Is the member matched to a housing program, housing voucher, or other publicly funded housing opportunity?*

☐ Yes: Please describe _____ ☐ No ☐ Unknown

Is member able to live independently?* ☐ Yes ☐ No

Provide Member's CHAMP I.D. if available: _____

Provide Member's HMIS I.D. if available: _____

Please share any additional information on the member's housing status and housing needs:

_____

Member Health Information

Does the member have any of the below health conditions?* ☐ Yes ☐ No ☐ Unknown

☐ Alcohol use disorder, ☐Asthma, ☐Bipolar disorder, ☐Chronic/congestive heart failure, ☐Chronic kidney disease, ☐Chronic liver disease, ☐Chronic obstructive pulmonary disease, ☐Coronary artery disease, ☐Dementia, ☐Diabetes, ☐Hypertension, ☐Major depression, ☐Psychotic disorder, ☐Other serious mental illness, ☐Other substance use disorders, ☐ Traumatic brain injury

How many Emergency Department visits did the member have in the last year?* Insert number of visits____ ☐Unknown

How many Inpatient visits did the member have in the last year?* Insert number of visits: _____ ☐ Unknown

Please share any additional information on the member's health needs:

_____