



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, Connections LTC 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

- 3. Transitional Rent - Rental Assistance
 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 6: South

SPA 2: San Fernando Valley

SPA 7: East

SPA 3: San Gabriel Valley

SPA 8: South Bay

SPA 4: Metro LA

Unknown

SPA 5: West

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: