Housing
Approval Request Form

The Alameda Alliance for Health (Alliance) Housing Approval Request Form is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may be appropriate for CS housing services, please complete the form below. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Attach a clinical summary and/or supporting documentation (ex. clinic notes, hospital discharge summary, etc.), for housing services.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed.

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: _____ NPI: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Office Contact Name: _____ Date of Request: _____

Subcontractor: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _ Alliance Member ID #: _____

Address: _____

City: _____ State: _ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

☐ Confirmed patient is not receiving duplicative support from other state, local, or federally funded programs, and has been considered first before using Medi-Cal funding.

Patient's Qualifying Condition (please select only (1) option):

☐ Option 1:
- Patient is experiencing homelessness; **AND**
- Has complex health, disability, and/or behavioral health conditions.

☐ Option 2:
- Prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System.

Patient's Additional Qualifying Condition(s) (please select all that apply, must meet at least one (1) to be eligible):

☐ Meets the Housing and Urban Development (HUD) definition of homeless as defined in section 91.5 of Title 24 of the Code of Federal Regulations: **www.dhcs.ca.gov/Documents/MCQMD/ILOS-Policy-Guide-September-2021.pdf**

☐ Receives Enhanced Care Management (ECM) services

☐ Receives care/case management

☐ Has more than one (1) serious chronic condition and/or serious mental illness and/or at-risk of institutionalization or requiring residential services as a result of substance use disorder

☐ Received Housing Transition Navigation Services (only applicable to Housing Deposits and Tenancy Support Services application)

Requesting Housing Navigation (please select all that apply)**:**

☐ Has significant barriers to housing stability

☐ Has one (1) or more serious chronic condition(s)

☐ Has a serious mental illness

☐ At risk of institutionalization or overdose, or have residential services because of a substance use disorder, or have a serious emotional disturbance (children and adolescents)

☐ Receives ECM services

☐ Are transition-age youth with significant barriers to housing stability such as one (1) or more conviction, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have serious mental illness and/or children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence

Requesting Housing Services (please select all that apply)**:**

- ☐ Transition Navigation Services
- ☐ Housing Deposits: $ _____
  - Patient has previously received Housing Deposits*
- ☐ Housing Tenancy and Sustaining Services
  - Patient has previously received Housing Tenancy and Sustaining Services*

***Please complete patient evaluation below.**

Patient Evaluation (please explain what conditions have changed to demonstrate why providing Housing Deposits or Housing Tenancy and Sustaining Services would be more successful on the second attempt):

Rendering Provider:

- ☐ HCSA (NPI: 1366623316)
- ☐ East Bay Innovations (NPI: 1699002634)

For Internal Use Only:

- ☐ No duplication
- ☐ Amount previously authorized (if applicable): $ _____
- ☐ Amount paid (if applicable): $ _____

Confirmed By:_____ Date: _____