

Referring Provider and Practice Name *

San Ysidro Health Center Inc

Referring Provider's Phone Number *

(619)-205-1360

Please enter a valid phone number.

Referring Provider's Fax Number *

(619)-205-1388

Please enter a valid fax number.

Referring Provider Email Address *

customer_support@syhc.org

example@example.com

Member's Name *

Nick

First Name

Smart

Last Name

Member's Date of Birth *

02-11-1981



Date

Member's Address

1750 Western Ave

Street Address

Street Address Line 2

San Diego

City

California

State / Province

Postal / Zip Code

Member's Phone Number

619-566-1286

Please enter a valid phone number.

Member's Contact *

nick002@gmail.com

(Please indicate the best way to get in touch with member)

Has the patient/member been informed that a CS referral is being requested? *

☒ Yes

☐ No

Has the patient/member indicated a preferred CS Provider? *

☐ Yes

☒ No

What is the primary problem/reason for the referral? Please select the reason that is most applicable to member's current situation. *

☐ Member needs assistance obtaining housing

☒ Member is in a home and needs assistance maintaining current living situation

Is the member currently receiving Enhanced Care Management? *

☐ Yes

☒ No

Housing Support Services

Please complete this section if requesting housing support services for the member.

Please check all that apply to the member

- ☐ Member is prioritized for a permanent supportive housing unit or rental subsidy or meets the HUD definition of homeless
- ☒ Member meets the HUD definition of at risk of homelessness

Please check all areas that apply to member below

- ☒ Has one or more serious chronic conditions and/or serious mental illness
- ☐ Is at risk of institutionalization or requiring residential services as a result of a substance use disorder

Housing Deposits

Please only complete this section if requesting housing deposit support for the member.

Has member received a housing deposit in the past?

- ☐ Yes
- ☒ No

Please indicate if the member would benefit from being reimbursed for any of the below (check all that apply)

- ☒ Security deposits required to obtain a lease on an apartment or home
- ☐ Setup fees/deposits for utilities or service access and utility arrearages
- ☐ First-month coverage of utilities
- ☒ First month's and last month's rent as required by landlord for occupancy
- ☐ Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy
- ☐ Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services designed to preserve an individuals' health and safety in the home

Please check any of the circumstances that apply to the member (more than one can be selected)

- ☒ Receiving Housing Transition/Navigation Services
- ☐ Prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System
- ☐ Meet the Housing and Urban Development (HUD) definition of homeless

Additional Comments

Review Answers