# San Diego Housing Support Plan (HSP)

## Member Information

**Member Name:** _____ **DOB:** _____
(First, Last) (MM/DD/YYYY)

**Medi-Cal CIN:** _____ **HMIS ID:** _____
(If applicable)

☐ Interpreter requested or required
Preferred language (if applicable): _____

☐ Housing Preferences and Needs Assessment on file and used to inform this Housing Support Plan

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## Services/Referral Type

☐ Housing Transition Navigation Services (HTNS)
☐ Housing Tenancy & Sustaining Services (HTSS)
☐ Housing Deposits (Requires permanent housing strategy and payment mechanism)
☐ Transitional Rent
- ☐ Interim setting (Requires County BH confirmation of BHSA **CLINICAL** eligibility for qualifying Specialty Mental Health Services)
- ☐ Permanent setting (Requires permanent housing strategy and payment mechanism)

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## Housing Support Plan Dates

*HSPs should be updated at least every 182 days or when the member has a significant change in their housing needs or strategy*

**HSP Creation Date:** _____
(MM/DD/YYYY)

# San Diego Housing Support Plan (HSP)

**HSP End Date:** _____ (182 days from the creation date)
(MM/DD/YYYY)

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## Permanent Housing Strategy and Solution

**Planned Permanent Housing Type after Transitional Rent ends:**

☐ Not applicable because the Member will be able to remain in the unit in which they plan to use their Transitional Rent

☐ Their own housing

☐ Shared housing

☐ Moving in with a family member or friend on a permanent basis

☐ Other (please specify): _____

_____

**What program(s) and/or payment source(s) does the Member plan to use to support their permanent housing once their Transitional Rent ends?**

*At least one realistic permanent housing funding source must be identified when requesting Transitional Rent or Housing Deposits.*

**Check all that apply and indicate the Member's current status.**

☐ Behavioral Health Services Act Housing Intervention

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Behavioral Health services resource (please specify): _____

_____

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Rental assistance program:

☐ Housing voucher. Please specify the type (e.g., Housing Choice Voucher, Mainstream Voucher, etc.): _____

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Rapid Rehousing Permanent Supportive Housing

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ State- or locally funded program (e.g., HDAP, HSP, TBRA, etc.) (please specify): _____

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Shallow subsidy (please specify program/ source): _____

_____

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Other: _____

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Assisted living/Board and Care

☐ Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Criminal legal system-funded housing program

☐Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Public Housing

☐Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ Family reunification assistance program

☐Enrolled/Confirmed ☐ Application Pending ☐ Exploring ☐ N/A

☐ None/Self-pay for housing

☐Enrolled/Confirmed ☐☐ Application Pending ☐ Exploring ☐ N/A

☐ Other (please specify): _____

☐Enrolled/Confirmed ☐☐ Application Pending ☐☐ Exploring ☐ N/A

**If the Member is not yet enrolled or confirmed in a selected program(s), describe how the program or resource will be secured before Transitional Rent ends:**

_____

_____

_____

**What is the Member's anticipated rent and utilities?**

Monthly Rent: $_____

Monthly Utilities and other costs not covered by the Transitional Rent benefit: (estimate): $_____

Other costs (groceries, transportation, school): $_____

**How will the Medi-Cal Member afford their ongoing housing costs?**

☐ SSI/SSDI/SSA: $_____

☐ Employment: $_____

☐ Rental Subsidy: $_____

Approved: ☐ Yes ☐ No

☐ Pending CalWORKs: $_____

☐ General Assistance: $_____

☐ Other (please specify): $_____

**County Behavioral Health Confirmation** *(Required for Interim Settings)*

☐ County Behavioral Health has confirmed the member is eligible for BHSA and related BHSA housing interventions. Members can transition to BHSA housing if they do not secure a long-term rental subsidy before Transitional Rent ends.

☐ Documentation on file.

## Housing Supports Needed for Permanent Housing Stability

**Select all the supports the member may need to obtain, maintain, or sustain permanent housing.**

*For any selected support the member is not currently receiving, document the barrier and planned action steps in the "Identified Housing Barriers, Goals, and Action Plan" section.*

*If the member declines a recommended support, document it below.*

☐ Enhanced Care Management (ECM)

☐ Community Supports:

- ☐ Housing Transition Navigation Services (expand below)
- ☐ Housing Tenancy & Supportive Services (expand below)
- ☐ Housing Deposit (expand in Housing Deposit section)
- ☐ Medically Tailored Meals
- ☐ Day Habilitation
- ☐ Other (please specify): _____

  _____

☐ Landlord Mediation

☐ Help with utilities

☐ Case Management, other than Enhanced Care Management

☐ Transportation Assistance

☐ Assistance Seeking Employment

☐ Assistance to Increase Income

☐ Assistance to Access Benefits

☐ Financial Literacy/Budgeting Assistance

☐ Representative Payee

☐ Behavioral or other Health Care Needs

☐ Other (please describe): _____

## Housing Transition Navigation Services (HTNS)

*Complete only if Housing Transition Navigation Services (HTNS) was selected above.*

**What activities does the member need support with to obtain housing?**

*Check all that apply*

☐ Housing search and option presentation

☐ Assistance with housing applications

☐ Obtaining identification or documentation needed for housing or benefits

☐ Support with SSI/SSDI application or documentation

☐ Rental subsidy or voucher identification and matching

☐ Identifying resources for deposits, moving costs, and one-time expenses

☐ Reasonable accommodation requests

☐ Landlord/property management engagement and education

☐ Unit safety/habitability prior to move-in

☐ Advocacy with landlord/property management

☐ Move-in planning and coordination

☐ Housing support and crisis plan development

☐ Non-medical transportation related to housing access

☐ Environmental modifications for accessibility

## Housing Tenancy & Sustaining Services (HTSS)

*Complete only if Housing Tenancy & Sustaining Services (HTSS) was selected above.*

**What activities does the member need support with to maintain housing stability?**

*Check all that apply*

☐ Early identification and intervention for behaviors that may jeopardize housing

☐ Tenant/landlord rights and responsibilities education

☐☐ Coaching to strengthen landlord/property manager relationships

☐ Coordination with landlord and case management

☐ Dispute resolution and eviction prevention (including repayment plans)

☐ Advocacy/linkage to community eviction prevention resources

☐ Benefits advocacy and SSI/SSDI support

☐ Annual housing recertification assistance

☐ Regular updates to housing support and crisis plan

☐ Lease compliance and household management support

☐ Health and safety visits or habitability monitoring

☐ Crisis plan interventions (e.g., new accommodation requests)

☐ Independent living skills development

☐ Financial literacy and budgeting support

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**Supports Declined by Member (if any):** _____

_____

_____

**Is the Member <u>currently</u> enrolled in any of the following programs?**

☐ Behavioral Health Bridge Housing (BHBH) funded programs (ie: interim housing)

☐ Behavioral Health Services Act (BHSA) funded programs (ie: FSP, SUD programs)

☐ CalWORKS Housing Support Program (HSP)

☐ Bringing Families Home (BFH)

☐ Housing and Disability Advocacy Program (HDAP)

☐ Home Safe

## Identified Housing Barriers, Goals, and Action Plan

**Member Strengths -** List strengths that will support housing goals: _____

_____

_____

**List barriers that directly affect the member's ability to obtain or maintain housing stability. For each barrier, include measurable goals and clear action steps¡.**
*(Minimum of two barriers required)*

| **Identified Housing Barriers** | **Goals** **(Short and Long Term)** | **Action Steps** | **Person(s) Responsible** | **Target Date** |
|---|---|---|---|---|
| | | | ☐ Member<br>☐ Housing Coordinator<br>☐ Case Manager<br>☐ Other: _____ _____ | |

| | | | | |
|---|---|---|---|---|
| | | | ☐ Member<br>☐ Housing Coordinator<br>☐ Case Manager<br>☐ Other: _____ _____ | |
| | | | ☐ Member<br>☐ Housing Coordinator<br>☐ Case Manager<br>☐ Other: _____ _____ | |

## Housing Deposits Referral Request

*Complete only if requesting Housing Deposits in addition to Transitional Rent*

**Check all goods and services that are reasonable and necessary due to the member's lack of income. Enter the requested amount for each item. Attach supporting documentation when submitting for authorization (e.g., lease, promissory note, utility bill, arrears statement, household goods list, invoice, estimate, or other applicable documentation).**

☐ Security deposit: _____

☐ Utilities setup/deposits: _____

☐ Utilities arrears: _____

☐ First month coverage of utilities: _____

☐ Application fees: _____

☐ Minor repairs:

_____

☐ Essential household goods:

_____

☐ Furniture:

_____

☐ Health/Safety items/services (describe):

_____

☐ Other (describe):

_____

## Care Coordination Team

Enter all providers currently supporting the member. The Housing Coordinator will coordinate with the care team to align housing goals, prevent duplicate services, and promote housing stability.

Confirm or obtain appropriate Releases of Information (ROI) before sharing information with anyone listed below.

| Provider Type | Name | Agency | Phone/Email |
|---|---|---|---|
| **Primary Care** | | | |
| **Enhanced Care Manager** | | | |
| **Behavioral Health** | | | |
| **Housing Coordinator** | | | |

| | | | |
|---|---|---|---|
| **Other Provider** | | | |
| **Family Member / Trusted Support (if member chooses)** | | NA | |

# San Diego Housing Support Plan (HSP)

## Acknowledgement & Signatures

**Please confirm all of the following and sign:**

☐This Housing Support Plan was developed in partnership with the member, reflects the member's preferences and needs, and will be updated as the member's circumstances change. Staff offered the member choice when setting priorities.

☐ Staff informed the member about the purpose of the HSP, how it will be used, and who will receive it.

Staff Name: _____

Staff Signature: _____

Phone: _____ Email: _____

Date: _____
(MM/DD/YYYY)

Supervisor Name: _____

Supervisor Signature: _____

Phone: _____ Email: _____

Date: _____
(MM/DD/YYYY)