Housing for Healthy California Program
Pre-Screening & Attestation Form

Thank you for your interest in applying for the Housing for Healthy California Program. The Housing for a Healthy California Program (HHC) is designed to provide supportive housing opportunities for individuals who are experiencing homelessness and are recipients of or eligible for health care provided through the California Department of Health Care Services (DHCS) Medi-Cal program.

To begin your application**, please submit the pre-screening and attestation form with the Authorization to Release Health Information form to HHCUnits@smcgov.org**. Applicants **must meet all of the criteria to be eligible**. If you cannot answer yes to all of the criteria listed below, the application will not move forward in the process.

Please note:

**It is necessary for this pre-screening, and the full application, that the Authorization to Release Information form is signed by the applicant (your client). If the release is verbal, you must document that on the form.*

***Eligible persons must be legal residents or a US citizen*.

Once the pre-screening application has been received and eligibility is confirmed, you will be sent a link to complete the application form. Documentation to verify eligibility must be sent within two weeks of completing the application form. The first round of applications will be accepted for 12 one-bedroom units available in April 2025 and 8 units available in 2026 at 2700 Middlefield Rd in Redwood City

Applicant Name: _____
Applicant DOB: _____
Medi-Cal ID Number: _____

☐ I have attached the signed Authorization to Release Health Information form; see below for form.

☐ Yes, the applicant is currently experiencing homelessness and/or chronic homelessness; see below for definition and documentation required.

☐ Yes, the applicant is enrolled in or eligible for a Medi-Cal Managed Care Plan (HPSM, Kaiser); see below for documentation required.

☐ Yes, the client has frequent hospitalization; see below for definition and documentation required.

☐ Yes, the applicant is connected to or eligible for long term in field-based case management.

☐ Yes, the applicant's household income does not exceed the Extremely Low Income (ELI) defined as 15%-20% of average median income.

Certification: I certify that the above stated information is true to the best of my knowledge.

Name & Title:	_____	Agency:	_____
Phone:	_____	Email	_____
Signature:	_____	Date	_____

Housing for Healthy California Program - Definitions

Homeless & Chronically Homeless Definition

Homeless (as defined in Section 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018); is defined as living on the streets or lacking a fixed regular and adequate nighttime residence (this includes shelters, motels and living situations in which the individual or family has no tenant rights).

Homeless could also mean they will imminently lose their primary nighttime residence, provided that:

(i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance.

(ii) No subsequent residence has been identified; and

(iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

Chronic Homelessness as defined in 578.3 of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2018, is defined as living in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been homeless except that a person who was experiencing chronic homelessness before entering an institution would continue to be defined as Experiencing chronic homelessness upon discharge, regardless of length of stay.

(i) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph 1

(ii) Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility.

Frequent Hospitalizatons Definition

Has had at least one inpatient hospitalization or three emergency room visits in the year prior to this application.

Supporting Documents

***The following documentation must be submitted within two weeks after completing the form. Documentations are needed to verify HHC eligibility and failure to submit documentation will delay application process*:**

1. Documentation of enrollment in or eligibility for Medi-Cal benefits such as Medi-Cal ID card, Medi-Cal management information system report.
2. Documentation of the person's status as Experiencing Homelessness or Experiencing Chronic Homelessness, which can be captured through any of the following:
    i. A client's entry and exits documented in the Homeless Management Information System (HMIS)
    ii. An outreach worker or Case Manager's written observations, or
    iii. A client's self-report of episodes of experiencing homelessness and disability status must be done in accordance with procedures established through CES, or other procedures established by the County for determining whether a person qualifies as Experiencing homelessness or
3. Documentation of a person's status as having frequent hospitalizations, which could be captured through any of the following:
    i. Discharge summaries, or other medical records.
    ii. An outreach worker, case manager, or local County's health department written observations.
    iii. Electronic health records
4. The client's household income documentation such as SSI, SSDI or bank statement.

SAN MATEO COUNTY HEALTH

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AUTHORIZATION FOR RELEASE OF WRITTEN OR VERBAL HEALTH INFORMATION

YOUR INFORMATION

Last Name/First Name:	Date of Birth:
Address:	City/State/Zip:
Medical Record Number:	Other Patient ID:

AUTHORIZATION

I HEREBY AUTHORIZE: (Party Releasing Information)	TO RELEASE TO: (Party Receiving Information)
Name:	County Health – Public Health, Policy and Planning, Homes for Health Program County of San Mateo Housing Authority Mercy Housing Mid-Peninsula Housing Affirmed Housing Core Affordable Housing
Role/Relationship:	
Address:	
City/State/Zip:	
Phone:	
Fax:	

DESCRIPTION OF THE INFORMATION TO BE RELEASED

The purpose of this release of information is to make a referral to the Homes for Health, Housing for Healthy California program. This information may be shared with the partners listed above to check for eligibility for the program as well as to evaluate the supports needed for successful housing.

☐ All Dates OR Enter date range for the records to be released: _____(date) to_____(date)
Please indicate the information you would like to release by selecting OPTION 1 or OPTION 2
☐ OPTION 1 Entire record including all medical/mental health, alcohol and drug, and HIV/AIDS information (this includes the release of all information below)

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All together better.

OPTION 2

Check each type of confidential information you authorize to be released:

General Information	Medical Information	Alcohol and Drug-Specific Information	Mental Health Information
☐Demographic Information ☐Discussion of my care with my physician ☐Make medical appointment(s) for me. ☐Financial Information ☐View my patient information. ☐My general status in a program, including goals, services I receive, and how to support my progress.	☐Any medical information related to my care. OR Only the following medical information (check all that apply) ☐Medications ☐Assessments Treatment Plan & Recommendations ☐Discharge Summary ☐Lab Results ☐HIV/AIDS Test Results ☐Dental Information	(excludes psychotherapy and SUD Counseling notes). Only the following alcoholand drug-specific information (check all thatapply) ☐Medications ☐Assessments ☐Diagnoses, Treatment Plan & Recommendations ☐Discharge Summary ☐Lab Results	(excludes psychotherapy notes) Only the following mental health information (check all that apply) ☐Medications ☐Assessments ☐Diagnoses ☐Treatment Plan & Recommendations ☐Discharge Summary ☐Lab Results

Only the following information/other information (please specify below):

PURPOSE

The purpose and limitations (if any) of the requested use or disclosure is/are:

Patient Request; *OR*

Other:_____

This authorization for release of the above information to the above named person(s) or organization(s) shall become effective immediately and shall remain in effect for one year from the date of signature, unless a different date is specified.

Enter date range here if less than one year:

For the following period of time:_____(date) to_____(date)

I understand that: I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. I have the right to cancel this authorization at any time by contacting the SMCHS that office prepared my records, in writing. The authorization will end on the date my valid, written cancellation request is received. For federally-assisted substance abuse programs and records subject to the Lanterman Petris Short (LPS) Act a verbal revocation must be accepted. The Notice of Privacy Practices provides instructions for me, as well as limitations on my cancellation, should I decide to revoke my authorization. My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. I have the right to receive a copy of this authorization and to obtain information on the disclosures made pursuant to this authorization. Reasonable fees may be charged to cover the costs of copying and postage. Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization(s) or person(s) I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Print Name of Client/Patient/Authorized Representative	Signature
Date/Time	If signed by someone other than the patient/client, include name and relationship

Patient/Client Primary Language	Interpreter name (as applicable)	Interpreter number (as applicable)