CalAIM: HOUSING SCREENING & ASSESSMENT

Housing Navigator:	**Date of Visit:**

Patient/Client

First Name:	Last Name:	Middle Name:
Date of Birth:	Phone Number:	CIN ID Number:

Service Information

Type of Service:	Authorization Approved?	Authorization Number (if approved)
☐ Housing Navigation ☐ Housing Deposit ☐ Housing Tenancy	☐ Yes ☐ No	

Family Type

☐ Single Female ☐ Female with Children ☐ Couple no Children ☐ Extended Family
☐ Single Male ☐ Male with Children ☐ Couple with Children

Are there others in the household? ☐ Yes ☐ No	If yes, how many including client? _____

Please list the names of tenants:

First Name:	Last Name:	DOB:
First Name:	Last Name	DOB:
First Name:	Last Name:	DOB:
First Name:	Last Name:	DOB:
First Name:	Last Name:	DOB:
First Name:	Last Name:	DOB:

Housing Status

☐ Living with family, friend, or host family ☐ Room, house, apartment you rent ☐ Hotel or motel ☐ Street
☐ Apartment or house you own ☐ Subsidized housing ☐ Car

Participant Information

Is the Participant a veteran? ☐ Yes ☐ No	Is the Participant pregnant? ☐ Yes ☐ No # of Months Pregnant? _____
Is the Participant disabled? ☐ Yes ☐ No	Does the Participant have any chronic conditions? ☐ Yes ☐ No ☐ Decline to state Specify:_____

Does the Participant have any serious mental illness/serious emotional disturbance? ☐ Yes ☐ No	Specify: _____
If yes, has the applicant received any psychiatric treatment? ☐ Yes ☐ No	

Does the Participant have substance use disorder/issues? ☐ Yes ☐ No	Specify: _____
Are there any identified past or current domestic violence issues? ☐ Yes ☐ No	Dates of Incidents: _____

Household Income

Client **Type of Employment**: ☐ Self Employed ☐ Employed ☐ Unemployed

If the Participant reports that he/she is not working, ask the following:

Are you currently looking for work? ☐ Yes ☐ No	Are you currently unable to work? ☐ Yes ☐ No

Frequency & Pay:

☐ Weekly $_____	☐ Semi-Monthly (15th and 30th) $_____
☐ Bi-Weekly $_____	☐ Monthly $_____

Rental History:

Current Landlord/Property Manager Name: _____	Current Rent Amount: _____
Reason for Leaving (if applicable): _____	
Previous Landlord/Property Manager Name: _____	Previous Rent Amount: _____
Reason for Leaving (if applicable): _____	

Unhoused History:

Have you been unhoused in the past? ☐ Yes ☐ No
If yes, please provide details, including the duration of homelessness and any programs or services you accessed during that time:

Rental Assistance:

Do you have a rental assistance voucher? ☐ Yes ☐ No	Are you seeking rental assistance? ☐ Yes ☐ No
If yes, please provide details on the type of assistance you are looking for and any specific requirements or programs you are aware of:	
Have you ever been evicted from a rental property? ☐ Yes ☐ No	

If yes, please provide details:
Have you ever been convicted of a crime? ☐ Yes ☐ No
If yes, please provide details:

Has the Participant received the following services through CalOptima before?

Housing Transition and Navigation Services ☐ Yes ☐ No	Housing Deposit ☐ Yes ☐ No
Housing Tenancy and Sustaining Services ☐ Yes ☐ No	
If so, were the services completed? ☐ Yes ☐ No	

Does the Participant meet one of the following conditions:

☐ Has moved twice or more in 60 days due to financial hardship
☐ Staying with others due to economic hardship
☐ Received written notice of losing housing within 21 days
☐ Living in a hotel or motel without financial assistance from charities or government programs
☐ Living in overcrowded housing (more than 2 people in a small unit or more than 1.5 people per room)
☐ Recently released from jail, a correction program, or a system of care (such as hospital, mental health facility, foster care)
☐ Living in unstable housing with a high risk homelessness
☐ Other: _____

Additional Notes (optional):

BUDGET WORKSHEET (Housing Assessment cont.)

Category	Description	Current	Goal
Household	Employment Income 1	$	$
	Employment Income 2	$	$
	Social Security/Disability	$	$

	Pension/Retirement	$	$
	Child Support	$	$
	Benefit or Others	$	$
	Total Income:	**$**	**$**
Housing	Mortgage or Rent	$	$
	Maintenance (average)	$	$
	Sub-total:	**$**	**$**
Transportation	Vehicle Payment	$	$
	Gas/Fuel	$	$
	Auto Insurance	$	$
	Auto Maintenance/Repairs	$	$
	Sub-total:	**$**	**$**
Utilities	Electric	$	$
	Natural Gas	$	$
	Water	$	$
	Trash	$	$
	Internet/Cable	$	$
	Mobile/Home Phone	$	$
	Sub-total:	**$**	**$**
Food	Groceries	$	$
	Dining Out	$	$
	Sub-total:	**$**	**$**
Loans	Credit Card Payments	$	$
	Student Loans	$	$
	Personal/Travel Loans	$	$
	Sub-total:	**$**	**$**
Personal	Clothing	$	$
	Children's Clothing	$	$
	Hair Cut	$	$
	Health/Gym	$	$
	Dry Cleaning	$	$
	Sub-total:	**$**	**$**
Children	Childcare	$	$
	Extracurricular Activities	$	$
	Tuition	$	$
	School Supplies	$	$
	Sub-total:	**$**	**$**
Miscellaneous	Child Support	$	$
	Donation/Tithe	$	$
	Gifts	$	$
	Entertainment (movies, music, etc.)	$	$
	Insurance (life, medical, etc.)	$	$
	Sub-total:	**$**	**$**
	Total Monthly Expense:	**$**	**$**
	Total Income- Total Expense:	$	$

AUTHORIZATION FOR RELEASE OF INFORMATION TO KCS

CLIENT INFORMATION:

Last Name:	First Name:	Middle Name:
Birth Date (MM/DD/YYYY):	Phone Number/Mobile Number:	

I hereby authorize and direct any federal, state, or local agency, organization, business, or individual to release to Korean Community Services, Inc. (DBA: KCS) any information, records, or materials (information) needed to complete and verify my eligibility for services under Enhanced Care Management (ECM) and/or other CalAIM- related programs and to facilitate my continued participation in these programs and services. This authorization includes otherwise Protected Private Information pursuant to the U.S. Privacy Act of 1974, the Health Insurance Portability and Accountability Act (HIPAA), the California Privacy Rights Act (CPRA), and other applicable State and Federal Privacy Protection Laws and Regulations.

I understand that this authorization and the information obtained because of it, is given to KCS to assist them in administering and enforcing rules, policies, and care coordination efforts, pursuant to the aforementioned programs and services I am benefiting from.

I acknowledge that, depending on program requirements, previous or current information regarding me or my household may be requested, including but not limited to: Identity and Marital Status; Medical and Behavioral Health Information; Employment (and Work History); Unhoused Status (and History); Special Needs and Support Services.

I understand that this authorization cannot be used to obtain any information that is not pertinent to my eligibility and continued participation in ECM and other CalAIM services.

The groups or individuals that may be asked to release information (depending on program requirements) include but are not limited to: Healthcare Providers, including Behavioral Health; Veterans Administration; Social Security Administration; Public Assistance Agencies (e.g., Medi-Cal, CalFresh, SSI, IHSS); Housing and Homeless Services Agencies; Employers and Workforce Agencies; Education Institutions and Child Services; Financial Institutions (e.g., Banks, Retirement/Pension); Law Enforcement and Legal Entities; Utility and Service Providers.

I understand and agree that KCS may conduct computer matching programs to verify the information provided for my application or recertification. If a computer match is conducted, I understand that my information may be exchanged with other federal, state, or local agencies, including but not limited to: State Employment Security Agencies; Department of Defense; Office of Personnel Management; U.S. Postal Service; Social Security Administration; State and Local Welfare Agencies; Food Stamp (SNAP) Agencies; Family and Social Services Administration (FSSA); Department of Child Services.

I agree that a photocopy or PDF of this authorization may be used for the purposes listed above. This authorization will stay in effect for as long as I remain an applicant, participant, or resident in any housing program administered by KCS.

I understand refusal to sign this or any required consent form may result in the denial or termination of services. I acknowledge, agree and understand that by typing my name in any section, it constitutes and will be treated as my signature.

Client Signature: _____ **Date:** _____

*This authorization will remain in effect for one (1) year from the date it is signed, or until it is formally revoked—whichever occurs sooner.

☐ ***I HEREBY REVOKE THIS RELEASE AUTHORIZATION.*** **Client Signature**:_____ **Date:** _____

KCS HIPAA AUTHORIZATION/RELEASE FORM

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends. Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

I,_____(**your name**), hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (i.e. physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

☐ Information is not to be released to anyone.

COMPLETE THE FOLLOWING BY INDICATING THOSE ITEMS THAT YOU WANT DISCLOSED.

☐ ALL HEALTH INFORMATION	☐ Patient Allergies	☐ Diagnostic Test Reports	☐ Other
☐ History/Physical Exam	☐ Operation Reports	☐ EKG/Cardiology Reports	☐ Mental Health Records
☐ Past/Present Medications	☐ Consultation Reports	☐ Pathology Reports	☐ Radiology Reports & Images
☐ Lab Results	☐ Progress Notes	☐ Billing Information	
☐ Physician's orders	☐ Discharge Summary	☐ HIV/AIDS Test Results/Treatment	

This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation received by the covered entity. A copy or facsimile of this original authorization shall be accepted as though it were an original document. I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

Patient Signature _____ **Date** _____