IEHP | Community Supports

Individualized Housing Support Plan

Referring Organization:				Date of Referral:
Referring Contact Name/Title:		Main Phone/Mobile #:		Email Address:
Member's First Name:	Middle Initial:	Last Name:	Member Mobile /Email:	IEHP Number:

Gender: ☐ Male ☐ Female ☐ Other: _____ Preferred pronoun:	DOB: Age:	**Primary Language:** ☐ English ☐ Spanish ☐ Other: _____	**Documents Needed:** ☐ CA ID or License ☐ Birth Certificate ☐ Social Security Card ☐ Rental History ☐ Income Verification	Interested in participating in Community Supports Services? ☐ Yes ☐ No

Current Location

☐ San Bernardino Proper
☐ West San Bernardino
☐ High Desert
☐ Riverside
☐ Low Desert
☐ Corona/Temecula/Hemet

Details of Member's current location:

Placement Location

Willing to be housed in any location in current County: ☐ Yes ☐ No
Willing to be housed in another County: ☐ Yes ☐ No
Previously in another housing program: ☐ Yes ☐ No

Area(s) Member CANNOT live in:

Past Medical History (Past 60-days)

☐ Urgent Care Visit
☐ Emergency Care Visit
☐ Hospitalization
☐ Psychiatric Hospitalization
☐ Residential Treatment for SUD
☐ PHP and/or IOP
☐ Recent Falls
☐ Surgical Procedures
☐ Wounds

Details of Member's past medical history:

Socioeconomic Status (Income)

☐ None
☐ Employed
☐ SSI/SSDI
☐ TANF/CalWorks
☐ Worker's Compensation
☐ Pension
☐ Other: _____

Adaptive Devices

☐ Cane
☐ Crutches
☐ Walker/Heavy Duty
☐ Wheelchair/Heavy Duty
☐ Wheelchair/Heavy Duty Wheelchair
☐ Wheelchair: Power Operated
☐ None
☐ Other: _____

Current Living Situation

☐ Single Family Home
☐ Room & Board
☐ Assisted Living
☐ Nursing Home
☐ Temporary Housing
☐ Shelter
☐ Street
☐ Park
☐ Car
☐ Other:

Please provide the current address, if applicable:

Potential Tenants

☐ Alone
☐ Spouse
☐ Child
☐ Relative
☐ Significant Other
☐ Other: _____

Please provide IEHP ID Numbers for all Tenants

Type of Housing Requested

☐ Single family home
☐ Apartment
☐ Mobile Home
☐ Room & Board
☐ Assisted Living Facility
☐ Section 8
☐ Low-income housing
☐ Senior apartments
☐ Other: _____

Animals/Pets

Does the Member have an animal?
☐ Yes ☐ No
Is animal a service animal or emotional support animal?
☐ Service animal
☐ Emotional support animal
☐ Neither
Describe the type and number of animal(s):

Special Considerations

- ☐ Domestic Violence
- ☐ Registered sex offender
- ☐ History of Arsen
- ☐ Past evictions/bad credit
- ☐ No income Cal Fresh: $ /month
- ☐ Combative behavior
- ☐ Terminal condition: _____
- ☐ Infectious condition: _____
- ☐ Other:

External Resources Needed
(check all that apply)

- ☐ Assisted Living Waiver Program
- ☐ Coordinated Entry System
- ☐ County Health
- ☐ County and City Housing Authorities
- ☐ Department of Behavioral Health
- ☐ Department of Public Social Services
- ☐ Housing Urban Development (HUD)
- ☐ Mental Health and SS Department

Internal Resources Needed from IEHP
(check all that apply)

- ☐ Enhanced Care Management
- ☐ Complex Care Management
- ☐ Housing Transition Navigation Services
- ☐ Housing Deposits
- ☐ Housing Tenancy and Sustaining Services

Mobility Status
(check all that apply)

- ☐ Ambulatory (no impairments)
- ☐ Cannot climb stairs
- ☐ Uses walker/cane/crutches
- ☐ Uses motorized wheelchair
- ☐ Uses manual wheelchair
- ☐ Cannot transfer independently

Current DME

- ☐ Commode
- ☐ Dentures
- ☐ Diabetic Supplies
- ☐ Glasses
- ☐ Hearing Aids
- ☐ Hospital Bed
- ☐ Hoyer Lift
- ☐ Oxygen
- ☐ Tube Feeding
- ☐ Slide Board
- ☐ Shower Chair
- ☐ Wound Care

Additional Assistance Needs
(check all that apply)

- ☐ Respiratory (supplemental oxygen)
- ☐ Incontinence
- ☐ Wound care
- ☐ Tube/Ostomy Care
- ☐ Daily Living Activities (hygiene, grooming)
- Other: ☐

Medical Conditions:

Developmental Disorder/Intellectual Disability:

Behavioral Health Conditions:

BH Hx:

SUD Hx:

Legal Hx:

Clinical Observation(s):

Member's current family / social support:

Risk Assessment:

Assigned Primary Care Physician:

Assigned Behavioral Health Provider:

Current Medications:

☐ Requires assistance with medications. If so, describe:

High Risk Medications:

- ☐ Insulin
- ☐ Anticoagulants
- ☐ Injectable medications
- ☐ Other:

Substance use:

- ☐ Past use (describe):
- ☐ Active (*date of last use, type*):

Sensory/Cognitive Impairments:

Occupation/Work History:

Can Mbr work? ☐ Yes ☐ No
If no, will Mbr apply for SSI/SSDI ☐ Yes ☐ No

Challenges/Barriers to Housing:

1.
2.
3.

Any additional information: