Recommendations to Improve Housing Deposits Implementation

Uplifting Promising Practices and Recommended Changes to Address Common Pain Points
Housing-Related Community Supports Standardization Advisory Committee

December 2024

Introduction: This document was created by members of the Housing-Related Community Supports Standardization Advisory Committee (the Advisory Committee), a group made up of Medi-Cal Managed Care Plans (MCPs), housing-related Community Supports providers, homeless Continuum of Care (CoC) lead entities, CA county departments, people with lived experience of homelessness (the majority of whom are Medi-Cal members), and others with an interest in improving the availability, efficacy, uptake and outcomes of housing-related Community Supports. This project is co-convened by CSH and Klurfeld Consulting, LLC, and was generously funded by the California Health Care Foundation.

This document focuses on recommendations to ensure all eligible community members experiencing homelessness can receive Housing Deposits when they are moving into housing. Housing Deposits is one of the three housing-related Community Supports the Advisory Committee focused on in 2024. These recommendations were uplifted through a workgroup process held during the Spring and Summer of 2024. The workgroup initially identified 24 promising practices, which were voted on, edited, brought to the full Advisory Committee, voted upon and narrowed down to the 10 recommendations included below. Thirty-seven organizations involved in the implementation of Housing Deposits voted on and offered edits to these recommendations. The Advisory Committee voted to share out any recommendations that received 75% of members' approval (Yes votes) or higher.

Recommendations are listed according to the Implementation Stage they correspond with. Some recommendations address pain points in multiple stages. See Appendix A for details on pain points uplifted by implementation stage. See Appendix B for additional recommendations with less than 75% approval from the Advisory Committee and workgroup members.

Implementation Stage	Recommendations and Best Practices from The Advisory Committee	% Yes Votes
Initiating Referral/ Request for Authorization	**1. Recommendation to the California Department of Health Care Services (DHCS):** DHCS should grant contracted CBOs providing Community Supports access to the Medi-Cal provider portal (both online Provider Portal & AEVS) by giving them a "provider enrollment pathway." This is important so that providers can track Medi-Cal enrollment, when renewals are needed, and track which MCP their members are assigned to (as these changes often occur between monthly file transfers and are also needed for making new referrals).	97.4%
Rationale for #1: Currently, Community Supports providers who have provider portal access through other contracts (e.g. physical or behavioral health providers) can look up clients' MCP and Medi-Cal coverage. However, many housing Community Supports providers do not have this access. Though some MCPs offer an online provider portal for their respective membership, this is challenging in multi-MCP counties. Provider training on use cases and benefits of using AEVS will promote its use. AEVS access could also improve Medi-Cal renewal rates and Community Supports referral rates.		

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Implementation Stage	Recommendations and Best Practices from The Advisory Committee	% Yes Votes
Initiating Referral/ Request for Authorization	**2. Best Practice:** Ensure that each MCP has a phone line that any Medi-Cal member can call, learn about Community Supports eligibility via phone and get a response in real time. Member Services Departments can be included in these efforts, after receiving training on Community Supports.	89.5%
Rationale for #2: MCPs are currently required to offer a phone line for Medi-Cal members and to display information about Community Supports on their websites. However, only some offer Community Supports intake or receive referrals over the phone, and many offer it via handoffs to other Departments who may need to call the member back, which is challenging for members experiencing homelessness who may not have easy phone access.		
Initiating Referral/ Request for Authorization	**3. Best Practice:** MCPs should work to ensure Housing Deposit (and Housing Trio) eligibility and referral information is shared with homeless services providers, and specifically posted in shelters, sent to CoCs, and given to 211 operators.	84.2%
Rationale for #3: Many staff and clients within the homeless services system are not aware of Community Supports services available within the community. This would help with education. Community Supports providers, Coordinated Entry partners, Public Housing Authorities, 211 and other information sharing partners[1] should also work together to ensure that information about Community Supports eligibility and Medi-Cal renewal processes is up to date, accurate and shared widely.		
Submitting Referral/ Request for Authorization	**4. Best Practice:** MCPs initially approve any allowable Housing Deposit expenses up to a certain dollar threshold, and providers submit (or keep) receipts for actual expenses afterwards.[2] This would eliminate the need for providers to submit quotes item by item at time of referral.	86.8%
Submitting Referral/ Request for Authorization	**5. Best Practice:** If the above recommendation (#4) is not possible and an MCP requires quotes for items, we recommend a standardized quote sheet template[3] be adopted for all Housing Deposit providers to use (with averages offered by providers accepted).	92.1%
Rationale for #4 & #5: Some MCPs require detailed information on HD costs by item with the referral. This adds a significant administrative burden for providers and may delay submission if all costs are not known at the same time. Eliminating (#4) or standardizing (#5) upfront quote process would help.		

[1] For resources like Housing Deposits, some communities may have other sources of similar support. It will be important for information sharing partners to understand differences in eligibility criteria, differences in goods and services available, and any limitations to each service (funding caps, once in a lifetime or certain period).

[2] It will be important that contracted providers understand expectations of record keeping, tracking purchases, and submitting receipts to reduce audit risk.

[3] Some Advisory Committee member agencies already have drafted a template to capture this information from Housing Deposit providers. This has been shared in the Advisory Committee Tools Library to promote this promising practice. Note: The Advisory Committee voted that this promising practice should only be adopted if Recommendation 4 is not encouraged by DHCS.

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Implementation Stage	Recommendations and Best Practices from The Advisory Committee	% Yes Votes
Submitting Referral/ Request for Authorization	**6. Recommendation to DHCS and MCPs:** It is a reasonable assumption that anyone meeting Medi-Cal income requirements meets the criterion of "inability to meet such expense [i.e. paying upfront approximately $5,000 for a Housing Deposit]" and use that logic for them to be pre-authorized, as long they meet the other eligibility criteria.	86.8%
Rationale for #6: Some MCPs require HD providers or referrers to demonstrate evidence of financial hardship, citing the Community Supports Policy Guide restrictions language around "inability to meet such expense". Since the vast majority of members enrolled in Medi-Cal have incomes less than 138% of the Federal poverty level, and the rest meet categorical eligibility, the goal is to remove this barrier.		
Communication of Decision to referrer/providers/ member	**7. Best Practice:** Automatic authorization for Housing Deposits to accompany authorization for Housing Navigation services. The authorization for Housing Deposits lasts as long as the Housing Transition Navigation Services (HTNS) authorization. Both can be extended if need be.	84.2%
Rationale for #7: Since all members who receive HTNS also meet criteria for Housing Deposits, auto authorization would remove a barrier of referral and approval and allow for quick action to secure units when the deposits are needed.		
Provision of service & Documentation	**8. Recommendation to DHCS:** Ask DHCS to ensure that once DHCS publishes its list of approved items for Housing Deposits, that providers not be required to justify the need for each approved item. (e.g. justify why a bed is a needed item, why a side table is, etc.).[4]	100%
Rationale for #8: Some MCPs require detailed justifications on each item within the HD referral request, which adds time and administrative burden. MCPs voiced concern that bias could impact reviews, and providers voiced that it isn't person-centered to require justification for DHCS-approved items, as the member ultimately decides what items are the top priority to help them stabilize in housing.		

[4] While providers should not be required to justify the need for each acceptable item on the Housing Deposits list of acceptable goods and services, providers should honor client choice and ensure that the client is consenting to purchases being made. This can be documented in the individualized housing supports plan.

Implementation Stage	Recommendations and Best Practices from The Advisory Committee	% Yes Votes
Provision of service & Documentation	**9. Recommendation to DHCS:** Request DHCS to update service activities for Housing Deposits to include two additional service activities and include separate funding[5] for administrative activities associated with implementation of Housing Deposits. The additional service activities include: 1) administrative activities for organizing the Housing Deposit as well as collecting and submitting documentation some MCPs are requiring of providers administering Housing Deposits and 2) coordination with other Community Supports providers.	78.9%
Rationale for #9: DHCS' current service definition for Housing Deposits focuses on purchased goods and expenditures and does not mention the administrative work nor the coordination work that may be involved specifically for Housing Deposits (not just for HTNS). Some MCPs therefore feel that they need explicit guidance to include those costs under this Community Support. Coordination service activities primarily apply in situations where two different providers are offering Housing Navigation and Housing Deposits to the same member and coordination is required to delineate roles and share information. Providers who are contracted for the Housing Trio altogether also note that the administrative activities associated with Housing Deposits are separate from administrative activities associated with HTNS and HTSS (e.g. time coordinating documentation for audits, time coordinating with MCPs, coordinating with other entities to avoid duplication, internal financial tracking and accounting staff).		
Billing & Payment	**10. Recommendation to DHCS:** Request DHCS update its pricing guidance to note that exceptions to limits ***should*** be made for households with special needs. Families requiring multiple bedrooms and ADA units are often more expensive and require increases to ensure all people experiencing homelessness are able to receive the benefit of Housing Deposits.	86.8%
Rationale for #10: While DHCS specifically stated that its August 2021 Community Supports pricing guidance was non-binding, many MCPs use the $5,000 recommended maximum for Housing Deposits across the board. This means that the service may not be truly available to larger families nor to individuals with disabilities because of the higher costs of those units.		

[5] For this to be successful, Advisory Committee members noted that it will be important that funding associated uniquely with Housing Deposits administrative activities not be taken from the $5,000 cap to be used for goods – and that, instead, the administrative activities are funded through a separate funding stream from DHCS.

Appendix A: Housing Deposits Workflow Stages and Pain Points Identified

Introduction: The chart below provides a description of the six workflow stages identified by workgroup members, along with common pain points experienced by MCPs and/or providers at each stage.

Workflow Stage Description	Pain Points
Stage 1: Initiating Referral / Request for Authorization	
A Housing Transition Navigation Services (HTNS) Community Supports provider, or other entity working with the member identifies a member in the process of housing search who is likely to be housed soon (or a member self-identifies). They identify that receiving financial assistance via a Housing Deposit and associated other move-in costs would be helpful, and decide to submit a referral for the Housing Deposits Community Support (HD). Before even submitting the referral, the referrer must know 1) that the member's Medi-Cal is active, 2) who their assigned Managed Care Plan (MCP) is and that the MCP offers HD, 3) that the member is likely to be eligible for HD, and 4) how and when to submit a referral for HD. Referrers also face varied timing constraints that are outside their control; often, the HD is needed from MCPs very quickly in order to secure leases with private landlords but for public programs (e.g. units secured through Public Housing Authorities) may take several months to go through.	1.1. Identifying MCP assignment: Community Supports providers and community-based organizations (CBOs) who aren't enrolled with Medi-Cal FFS don't have access to the state Medi-Cal Provider Portal nor AEVS, and often have difficulty identifying which MCP a person is assigned to. 1.2. Clarifying member eligibility criteria: Different MCPs have slightly different understandings of the HD eligibility criteria in the Community Supports Policy Guide, and different staff within each MCP sometimes also make different interpretations. 1.3. Non-HTNS Housing Navigation services: Medi-Cal members experiencing homelessness who are receiving housing navigation-type services from a non-Community Supports provider (e.g. COC-funded) are not currently eligible to receive HD, according to some MCPs' understanding of eligibility criteria. This barrier especially affects Coordinated Entry System (CES) partners. 1.4. Other Housing Transitions: Medi-Cal members who have just moved into permanent supportive housing (PSH) or are changing units may need HD to retain housing, but are not eligible, according to current DHCS guidance. 1.5. Lack of member education: Medi-Cal members who may qualify aren't sure if they are eligible and don't know how they would request the service. 1.6. Verifying once in a lifetime: Community Supports Providers and CBOs who want to refer members cannot easily know if member has already received this once in a lifetime service from their MCP. MCPs generally do not know if the member previously received the service from another MCP.

Workflow Stage Description	Pain Points
Stage 2: Submitting Referral / Request for Authorization	
Once a member has been identified as a potential candidate for HD, the process of actually submitting the referral (a.k.a. request for authorization) varies significantly by MCP. Seemingly all MCPs require some type of prior authorization for this service. Member eligibility criteria: Seemingly all MCPs require information at the time of initial referral to verify that the member meets eligibility criteria. However, they require different types of documentation to do this (e.g. some MCPs require referrers to provide evidence that the member can sustain ongoing rental payments, others require documentation to prove that members are unable to meet the HD expenses on their own, etc.). HD items authorized: MCPs also vary in how and when they intake information on what specific expenses will be under HD. While some MCPs offer a global authorization for any necessary HD items within the service definition, others require a high-level quote up front, and still others require detailed information on exact items and costs at time of submission. Some MCPs also require additional documentation such as lease documents or utility bills to accompany the initial request. Submission Process: Referrals are generally submitted via secure fax, secure email, and/or online provider portals, depending on the MCPs. Referrers must usually use the specific HD form for that MCP. If the referrer is an HTNS provider who is also a contracted HD provider with that MCP, then they are likely responsible for both Step 1 and Step 2. However, if the two entities are different, there is also coordination needed between the HTNS and HD entities to submit information for the referral.	2.1. Documentation volume: Providers state that MCPs ask for a high level of documentation during the initial request for authorization, including documentation that may not yet be available. It takes significant administrative resources for providers to gather this information and provide it to MCPs. MCPs state that they feel uncertain about how to demonstrate medical necessity effectively for this service, in order to be audit ready, and that they prefer to have information up front rather than chase providers for it after the fact. 2.2. Clarifying member eligibility criteria: See number 1.2 above; both understanding of eligibility requirements AND level of documentation requested vary by MCP. 2.3. Clarifying HD items eligible for authorization: Provider uncertainty regarding what items and dollar amounts each MCP will approve for HD for each approved member. 2.4. Different forms / documentation: Providers in regions with multiple MCPs must use different forms for each one, which adds to administrative burden. 2.5. Timeliness: Given that HD are often needed in 24 to 48 hours to secure leases from private landlords, there is a need to reduce any time-consuming steps leading up to authorization. 2.6. Different HTNS & HD providers: When HTNS and HD providers are different, how do they coordinate to collect the documentation needed for an initial referral and submit it to the MCP? This is also often an unreimbursed service for both parties.

Workflow Stage Description	Pain Points
Stage 3: MCP review, decision-making, & provider-matching	
Once the referral has been submitted, the MCP is responsible for reviewing it to ensure that the member meets criteria, that the request is medically appropriate, and that the request is reasonable and compliant with HD program requirements. Responses are usually reviewed one by one by various Utilization Management (UM) or related staff members, with few to no MCPs having automated the HD prior authorization process. The MCP may request additional information from the referrer if needed. For requests submitted by a contracted HD provider, the MCP almost invariably matches back to that provider to authorize HD services. But for requests submitted by another entity (for example, a contracted HTNS provider who does not offer HD), the MCP will need to select an HD provider. The MCP then issues an authorization for HD. MCPs vary in how quickly they said they were able to complete this step; some stated they usually took 1 business day or less but others used the standard authorization timeframes.	3.1. Prior authorization: Providers wondered if all MCP clients receiving HTNS could be automatically preauthorized for HD, without needing to individually submit requests; MCPs wondered if DHCS would support this and if it would be operationally feasible. 3.2. Inconsistent decision-making w/in and across MCPs: Providers described inconsistencies within the same plan and across multiple plans re: which members and which HD items they would approve. This creates a high administrative burden for providers and the potential for some members to be excluded despite meeting eligibility criteria. 3.3. Lack of reference materials: MCPs experience a lack of clarity and external references to train UM staff to review HD services in a way that would meet audit standards. 3.4. Timeliness: See 2.5 above. The existing MCP turnaround standards for urgent (72 hours) or standard (5 business days) authorization processing don't align with the 24 to 48 hour timelines of many private landlords. 3.5. Lack of HD providers: Many HD providers only want to serve their own HTNS members and many HTNS providers don't all want to do HD, leading to potential gaps in MCP networks for HD.
Stage 4: Communication of Decision to referrer, provider, and member	
Once the authorization has been created, MCPs must communicate the information to external parties in a timely way. MCPs generally send authorization approval / denial letters to HD providers via secure fax and/or provider portals, and to members via US mail. Some MCPs also send an email heads up to the HD provider and/or to the referrer if different, but this is not a consistent practice. According to the MCP Medi-Cal Contract (Exhibit A, Attachment III, Section 4.5.7.F on p. 264), MCPs are required to notify the referrer,	4.1. Timeliness: See 2.5 and 3.4 above. Communication to the HD provider may take a few days, which can exacerbate overall HD timing challenges. 4.2. Lack of communication to referrer: Referring entity (e.g. HTNS provider different from HD provider) often doesn't hear about decision to authorize member, for example if the notification letter is mailed or faxed to a general administrative address. This inhibits timely action and can make it harder for an HD provider to find the member if not the same agency as HTNS provider.

Workflow Stage Description	Pain Points
the authorized provider (if different), the member, and the ECM provider (if there is one) of all Community Supports authorization decisions.	4.3. Member communication: If the member has no mailing address, how does the member receive notice of approval? Also, authorization letters to members may arrive late (i.e. after the HD service was provided), leading to confusion.
Stage 5: Provision of service & documentation	
Once authorization is received, the contracted HD provider delivers the service. This often involves coordinating and documenting timely payment to multiple entities (e.g. landlord, various utility providers, movers, pest control, cleaners, etc.). It also involves working with the member to choose furnishings and household goods. The process can often be both logistically and emotionally challenging for members, especially for individuals with long histories of homelessness or other challenges. In addition, the HD provider may also need to coordinate with the Enhanced Care Management (ECM) provider and/or HTNS provider (if different) to complete the episode of Housing Navigation, as well as plan for continued housing stability and a potential transition to Housing Tenancy Sustaining Services (HTSS). MCPs offer various authorization lengths for HD providers to complete these activities. Some offer as few as 30 days, while others offer 90, 180, or 365 days for the initial authorization, with or without the possibility of extension. However, the time to complete the process varies greatly for HD providers; for units with private landlords, 30 to 90 day authorizations may be very tight but doable for most HD items. However, the timelines can be much longer for move-ins to units that are connected to a Public Housing Authority voucher (e.g. due to time needed to complete PHA inspections and agreements) or a project-based Permanent Supportive Housing site (e.g. when a Certificate of Occupancy for a new building is delayed, thus delaying move-ins). HD providers are usually working to meet as many of the member's housing needs as possible within a fixed budget; for some MCPs, the	5.1. Length of Authorization: Shorter authorization periods (30 to 90 days) will likely not be long enough for move-ins to units connected to PHAs and/or new PSH. 5.2. Clarifying CalAIM provider roles: Not clear how the HD, HTNS, and ECM providers coordinate work and share documentation, including updates to the ECM care plan and/or Individual Housing Support Plan. Who collects and shares the move-in date? Who assesses and refers to HTSS, if needed? 5.3. Housing Plan Changes: If a housing plan falls through after an HD authorization was issued, the HD provider will likely need to cancel and resubmit or modify the authorization once another opportunity is available. For MCPs who provide some sort of financial advance for HD, it's unclear what HD providers should do with the advance if housing falls through. 5.4. Funding adequacy: Funding limits for HD are often not enough to account for recent inflation, nor to secure larger units for families or ADA compliant units for members with disabilities.

Workflow Stage Description	Pain Points
budget is up to an overall global max (e.g. no more than $5,000 for all HD spending), while other MCPs have a spending cap for each individual item within HD. Unfortunately, the specific housing opportunity may fall through even after an HD authorization is issued. Depending on the MCP, this may result in the need for a new or modified authorization.	
Stage 6: Billing and Payment	
Payment processes and timing for HD vary significantly across MCPs. Many MCPs provide retrospective payment to HD providers based on receipt of a clean claim, which can be several months after the initial cash outlays. Some MCPs require providers to submit claims for all HD items at once, while others allow for submission on a flow basis. A few MCPs offer advance funding to assist HD providers with cash flow, whether via contracted funds or grants. In terms of what is paid for, all MCPs reimburse HD providers for the actual costs of the HD expenditures to external parties, usually up to a defined dollar limit. In terms of administrative and coordination work, only some MCPs reimburse for this; some provide an administrative fee for HD providers, while others fund the work through the HTNS Community Supports rate instead.	6.1. Cash flow: Payment timing is a major issue for HD providers. For most CBOs, waiting for retrospective reimbursement via claims 30 to 90 days after expenditure is not financially feasible for multiple HD clients at around $5,000 each. HD providers also mentioned staffing challenges or process changes causing additional delays for some MCPs. Delayed payment was mentioned multiple times in the initial prioritization survey. 6.2. Lack of HD providers: See number 3.5 above. MCPs shared challenges at recruiting enough HD providers, many related to the financial burden of retrospective MCP payments. 6.3. Lack of administrative funding: HD providers who did not receive administrative funding from their MCPs described it as a barrier to covering the costs of providing HD, especially when HD and HTNS providers are different for the same member. Some MCPs felt restricted by the Community Supports Policy Guide which defines staff work around administration of HD as part of HNTS. 6.4. Different payment & payment documentation requirements: Different MCPs have different HD payment methodologies and may also require different processes for documentation (e.g. submitting receipts with the authorization vs. with the claim vs. via a provider portal vs. not at all). This adds to administrative burden. 6.5. Documentation for advances: Thos MCPs who do provide advance payments described challenges getting receipts from HD providers after the fact.

Appendix B: Additional Housing Deposits Recommendations Uplifted from the Housing Deposits Workgroup

Introduction: The recommendations listed below were uplifted within a workgroup that was made up of members of the Housing-Related Community Supports Standardization Advisory Committee. Recommendations below did NOT receive full Advisory Committee support to be shared publicly as official recommendations; however many received support from more than 50% of workgroup or Advisory Committee members. For transparency, these recommendations are being shared with Advisory Committee member agencies and Associations so that others can understand some of the common pain points and possible solutions that were uplifted, despite not receiving resounding support from all Advisory Committee members.

Other Advisory Committee Recommendations[6] for Housing Deposits	AC Yes vote %
a. MCP should send approval letters within 24 hours, but also email referring entity, Housing Deposits, Housing Navigation, and ECM providers and approved member within 24 hours.	71.1%
b. MCPs pay providers an upfront amount (as an advance) to providers to cover the costs – see HealthNet pilot and Kaiser Permanente Project HOME. This upfront payment could be either an advance of funding for each authorization, or an advance of certain amount to cover multiple members. This would require settling accounts and paying back unspent advances or applying to the next member served. It could be operationalized via grants, contract funds, or another mechanism.	63.2%

[6] While the Workgroup developing recommendations uplifted 24 total recommendations, only 12 recommendations received enough support from all Workgroup members to then be brought to the entire Housing-Related Community Supports Standardization Advisory Committee. Of the 12 recommendations voted on by the Advisory Committee, 10 received more than 75% yes votes to move forward to be published and two did not. These two are here in this first section, along with the percent Yes votes they received from the 37 voting agencies of the Advisory Committee.

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Other Workgroup 2 Recommendations[7] for Housing Deposits	WG 2 Yes vote %
A. Standardized Eligibility- that anyone receiving Housing Navigation be deemed automatically eligible for Housing Deposits.	69%
B. Managed Care Plans can offer admin fee payments to Housing Deposit providers to cover administrative costs for coordinating and collecting/submitting documentation	69%
C. Managed Care Plans can work with a statewide Housing Deposits administrator that coordinates with Community Based Organization providers.	69%
D. Recommend DHCS ask MCPs to authorize anything from list that provider & client identify as needed, up to certain dollar amount. Note: this is similar to a previous recommendation, but this possibility includes asking DHCS to weigh in	69%
E. All Housing Deposits Authorization last for 180 days- this meets PHA and project –based PSH needs… AND helps when members with behavioral health needs require more time to stabilize in unit before making furniture decisions.	69%
F. Housing Deposits provider is paid an administrative coordination fee for each deposit and then required to hold the responsibility to reach out to Housing Navigation provider to coordinate and collect documentation. Housing Navigation provider leads for unit visits/search and communicates updates with Housing Deposit provider within one business day.	69%
G. MCP funds upfront costs for initial Housing Deposits (via grants) and offers training to Housing Navigation providers and Housing Tenancy Sustaining Providers to build capacity to become Housing Deposit providers.	62%
H. A Housing Deposit needs assessment form could include the Z code of homelessness as enough to justify need for services/evidence of need for services. It could be a check box option with the z codes.	54%

[7] These recommendations were not voted on by the full Advisory Committee but are here as a reference should Advisory Committee member agencies wish to adopt these strategies, dig in further, or offer feedback to DHCS. These are lettered A-L so as not to confuse recommendations with the numbered recommendations voted on by Advisory Committee members in September 2024.

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I. Some MCPs requiring documentation that member can support ongoing rent costs. Recommend that the provider simply check a box attesting that they have verified that this is true and the provider keep a summary budget in member's file documenting that the member can support ongoing rent. The provider would then only be required to submit the budget if requested during an audit.	54%
J. If no advance is possible, payment should arrive within 24 hours from MCP to provider, including landlord incentive reimbursement to hold unit.	46%
K. Housing Navigation provider submits move in date to MCP in monthly file.	46%
L. Ask to DHCS: de-couple Housing Deposits from Navigation- many people need it who received navigation from another source (like Homeless Continuum of Care providers/Coordinated Entry) or who are living in PSH but needing to move.	38%

Questions or comments about the recommendations or the Advisory Committee can be directed to the co-facilitators of the group:

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