MEMORANDUM

To:	Disability and Aging Services Commission
From:	Kelly Dearman, Executive Director, Department of Disability and Aging Services (DAS) Michael Zaugg, Director, DAS Office of Community Partnerships
Date:	July 1, 2026
Subject:	Community Living Fund Program - Annual Plan for Fiscal Year 2026-2027

Section 10.100-12 of the San Francisco Administrative Code created the Community Living Fund to fund aging in place and community placement alternatives for individuals who may otherwise require care in an institution. The Administrative Code requires that the Department of Disability and Aging Services (DAS) prepare Annual Plans to be submitted to the Disability and Aging Services Commission and have input from stakeholders. Attached is the Annual Plan for FY 2026-27, which has been prepared by DAS for the continuing implementation of the Community Living Fund Program administered by Institute on Aging (IOA).

DAS continues to maintain relationships with key stakeholders at the Department of Public Health and other City agencies, including:

- Daniel Tsai, Director, Department of Public Health
- Luis Calderon, Director of Placement, Department of Public Health
- Marion Sanders, Chief Deputy Director, Department of Homelessness and Supportive Housing
- Diltar Sidhu, Chief Executive Officer, Laguna Honda Hospital and Rehabilitation Center
- Albert Lam, Chief Medical Officer, Laguna Honda Hospital and Rehabilitation Center
- Janet Gillen, Director of Social Services, Laguna Honda Hospital and Rehabilitation Center
- Todd Barrett, Chief Medical Officer, San Francisco Health Network

Contents

Program Purpose, Target Populations, and Eligibility 3
Service Overview 3
Program Access and Service Connection 4
Program Operational Plans 5
Anticipated Expenditures 6
Projected CalAIM Revenue Received 7
Public Reporting Timeline 7
Appendix A: Client Eligibility Criteria 9
Appendix B: CLFP Caseload 11

PROGRAM PURPOSE, TARGET POPULATIONS, AND ELIGIBILITY

The Community Living Fund (CLF) serves as a funding source dedicated to the Community Living Fund Program (CLFP), administered by the Institute on Aging (IOA). This program aims to reduce unnecessary institutionalization.

CLFP serves older adults and adults with disabilities whose incomes are up to 300% of the federal poverty level, willing and able to live in the community with support as an alternative to institutionalization (for detailed eligibility criteria, see Appendix A on page 9). The program serves two populations of focus including: (1) skilled nursing facility residents who are transitioning back to the community; and (2) individuals living in the community who are at imminent risk of being institutionalized.

Nursing facility residents remain a priority to ensure safe community discharge and reduce re-institutionalization. CLFP focuses on reducing care disparities and promoting culturally responsive services. The program tailors support to each client's language, culture, and service needs.

SERVICE OVERVIEW

The mission of the CLFP remains unchanged for FY 2026–27 and continues to be carried out through the following four major service components:

Traditional CLFP Services

Traditional CLFP clients receive support through intensive case management and/or purchase of services to help maintain stability in the community. Proactive outreach and coordinated care enable clients to better navigate systems, access resources, and overcome barriers to aging in place.

Public Guardian Housing Fund Services

CLFP provides housing assistance to Public Guardian clients who meet traditional eligibility criteria and are conserved due to cognitive or other significant impairments. Subsidies from the PG Housing Fund help these individuals maintain stable housing in the community.

DAS Enhanced Care Management (ECM) Services

In July 2023, DAS launched its first contract with the San Francisco Health Plan (SFHP) to expand CLFP services through ECM, as part of CalAIM initiative. CalAIM is a statewide initiative designed to transform Medi-Cal into a more coordinated,

person-centered, and equitable health system. IOA provides the ECM services under subcontract with DAS. ECM clients receive intensive coordination of care, similar to traditional CLFP services, helping them navigate systems, connect to resources, and address barriers to stability.

DAS Community Supports Services

In July 2024, DAS entered into a second contract with SFHP to deliver Community Supports services (like ECM, administered through a subcontract with IOA). This component is also funded through CalAIM. Community Supports provide tailored, non-medical services to help Medi-Cal members address social needs that affect their health. DAS Community Supports component includes two types of services:

1. **Community Transition Services (CTS) to Private Residences**
   CTS services facilitate safe transitions from institutional care to the community through housing navigation, transition support, essential household items, and coordination of post-discharge needs.
2. **Nursing Facility Transition/Diversion (NFT/D) to Assisted Living Facilities**
   NFT/D assists assist individuals who are in nursing facilities or at risk of being placed in such facilities to transition or divert them to assisted living settings. Support includes transition planning, placement assistance, and ongoing subsidies for wraparound services at assisted living facilities.

PROGRAM ACCESS AND SERVICE CONNECTION

CLFP's referral and client engagement processes are expected to remain unchanged in FY 2026–27. Referrals for traditional CLFP, ECM, and Community Supports enter through two primary pathways:

1. Community members may submit referrals by contacting the DAS Benefits and Resource Hub, where Intake staff conduct an initial eligibility screening before forwarding eligible individuals to IOA for enrollment and service initiation. If any community referrals are identified as potentially eligible for ECM or Community Supports services, these referrals will be routed to SFHP for the following process.

2. SFHP sends monthly batch referral files for ECM and Community Supports services. DAS Intake conducts initial outreach for up to four weeks, after

which referrals are sent to IOA for continued outreach and engagement, with a total outreach window of up to eight weeks.

Referrals for Public Guardian Housing Fund Services come exclusively from the Public Guardian Office. CLFP works closely with the Public Guardian Office to identify eligible clients for this component.

Once a referral reaches CLFP, a care manager contacts the participant, confirms consent, completes an application, and conducts an in-home or in-hospital assessment. This assessment, completed within one month, guides the development of an individualized service plan in collaboration with the participant and their support system. If another care manager is already involved, CLFP coordinates the assessment accordingly.

In addition to the model of a combination of case management and purchase of services, some individuals only need specific goods or services to remain stable in the community. For these purchase-only clients, the CLFP care coordinator at Catholic Charities conducts a streamlined assessment to expedite access to needed supports. This flexible approach broadens CLFP's reach and helps prevent unnecessary institutionalization.

PROGRAM OPERATIONAL PLANS

Integrated Housing Model

CLFP will continue to partner with the Scattered Site Housing and Rental Subsidy Administration program, managed by Brilliant Corners and funded by the CLF as well. This program provides housing opportunities and rental subsidies that support affordable, independent community living.

Multidisciplinary Team Collaboration

CLFP will continue participating in the Community Options and Resource Engagement (CORE) group, a multidisciplinary team led by Laguna Honda Hospital that meets bi-weekly. Participants include community-based organizations, SFHP, and relevant City agencies. CORE meetings coordinate safe discharges and transitions from Laguna Honda Hospital to community settings.

Service Documentation

To ensure compliance with ECM documentation requirements, CLFP will implement a new progress note template to streamline documentation of the seven core ECM services, including outreach and engagement, assessment and care management

plan, enhanced coordination of care, health promotion, transitional care services, member and family support, as well as referrals to social support services.

Data Collection & Reporting

The program previously used two data systems — CASECare and PACECare Online (PCO). In August 2025, CASECare data were migrated into PCO which now serves as the only platform. This consolidation caused temporary disruptions to service documentation and reporting. In FY 2026-27, CLFP will continue to work with the database vendor to resolve these issues and enhance data collection to close identified data gaps.

Stakeholder Input

CLFP Advisory Council was established in January 2009 and will continue its regular meetings in FY 2026-27. The Council is comprised of representatives from consumers, partner agencies, and the community. The Advisory Council reviews and provides input on the consumer satisfaction surveys, program updates, and other topics that may affect service delivery.

CLFP gathers client feedback through annual satisfaction surveys, which will remain in place in FY 2026-27. Survey results inform program outcomes and guide improvements.

ANTICIPATED EXPENDITURES

At the conclusion of FY 2025-26, it is estimated that CLF will have expended a total of $107 million since the inception of CLFP. For FY 2026-27, the programs funded by the Fund are projected to be a total of $11.7 million in expenditure. The following table offers a detailed breakdown.

Table 1. Anticipated CLF Expenditures, FY 2026-27

CLF-Funded Program	Expenditure
Community Living Fund Program	$6,699,944
Public Guardian Housing Fund	$378,584
Scattered Site Housing and Rental Subsidy Administration Program	$3,481,756
Data system	$96,000
DAS internal staff	$796,344
Grant Total	**$11,656,628**

PROJECTED CALAIM REVENUE RECEIVED

DAS received an estimated $2.8 million in CalAIM revenue for ECM and Community Supports services rendered from the launch of DAS ECM in 2023 through the end of FY 2025–26. The table below provides a detailed breakdown. Figures for FY 2025–26 are estimates, as the payment for services rendered in June 2026 had not yet been received at the time of this report and is expected in mid-July 2026. Revenue expected in FY 2026–27 is projected to be approximately $2 million for both ECM and Community Supports.

Table 2. Revenue Received through CalAIM, July 2023 - June 2026

Fiscal Year	Enhanced Care Management	Community Supports	Annual Total
FY 2023-24	$289,800	n/a[1]	**$289,800**
FY 2024-25	$742,713	$99,684	**$842,397**
FY 2025-26	$900,000 (est.)	$778,000 (est.)	**$1,678,000 (est.)**
Grand Total	**$1,932,513 (est.)**	**$877,684 (est.)**	**$2,810,197 (est.)**

PUBLIC REPORTING TIMELINE

The public reporting timeline in FY 2026-27 is outlined below.

- **September-October 2026**:
    - Conduct data analysis for CLF six-month report for January-June 2026.

- **November 2026:**
    - Draft the report for January-June 2026.
    - Seek input from stakeholders on the report draft for January-June 2026.

- **December 2026**:
    - Submit the report to Disability and Aging Services Commission for review.
    - Forward the report to the Board of Supervisors.

- **April-May 2027**:
    - Conduct data analysis for CLF six-month report for July-December 2026.

[1] Community Supports services were not available in FY 2023-24 since this component was launched at the beginning of FY 2024-25.

- **June 2027:**
  - Draft the report for July-December 2026.
  - Draft the annual plan for FY 2027-28.
  - Seek input from stakeholders on the report drafts.

- **July 2027**:
  - Submit the reports to Disability and Aging Services Commission for review.
  - Forward the report for July-December 2026 to the Board of Supervisors.

APPENDIX A: CLIENT ELIGIBILITY CRITERIA

A. **Traditional CLFP Eligibility** - all of the following criteria for a person who is:
   1. Aged 18 years or older;
   2. A resident of San Francisco;
   3. Living in an institutional setting or assessed to be at imminent risk of institutionalization primarily due to functional or chronic health needs;
   4. Willing and able to live in the community with appropriate support;
   5. Having an income at or below 300% of federal poverty level;
   6. Having individual assets up to $130,000 for case management services or up to $6,000 for purchase of services only;
   7. Demonstrating a need for services or resources to prevent institutionalization and support community living.

   Preference is given to the following groups of people who are willing and able to live in the community with appropriate support.
   1. Patients of Laguna Honda Hospital and Zuckerberg San Francisco General Hospital
   2. Patients at other San Francisco acute care hospitals and skilled nursing facilities
   3. Nursing home eligible individuals on the waiting lists of Laguna Honda Hospital, Zuckerberg San Francisco General Hospital, or other hospitals
   4. Individuals at imminent risk of institutional placement

B. **Public Guardian Housing Fund Eligibility** – both of the following criteria for a person who is:
   1. An existing client with DAS PG program;
   2. Meeting the traditional CLFP eligibility criteria (see section A).

C. **DAS Enhanced Care Management (ECM) Eligibility** - all of the following criteria for a person who is:
   1. A member of San Francisco Health Plan (SFHP);
   2. A resident of San Francisco;
   3. An adult belonging to one of the following populations of focus:
      a. Adults living in the community and at risk of long-term care institutionalization;
      b. Adult nursing facility residents transitioning to the community;
   4. An individual who is willing and able to live in the community with appropriate support.

D. DAS Community Supports (CS) Eligibility

1. Community Transition Services Eligibility - all of the following criteria for a person who is:
   a. Eligible and enrolled in DAS ECM program (see section C);
   b. Currently receiving medically necessary nursing facility level of care (LOC) services and opting to transition to a home setting—rather than remain in a nursing facility or medical respite—while continuing to receive the required LOC services;
   c. Living in a nursing home and/or medical respite setting for 60+ days.

2. Nursing Facility Transition to Assisted Living Facilities Eligibility – all of the following criteria for a person who is:
   a. Eligible and enrolled in DAS ECM program (see section C);
   b. Living in a nursing home and/or medical respite setting for 60+ days;
   c. Requiring placement in an assisted living facility or a similar level of care setting based on assessment;
   d. Willing and able to safely transition to an assisted living facility.

3. Nursing Facility Diversion to Assisted Living Facilities Eligibility – all of the following criteria for a person who is:
   a. Eligible and enrolled in DAS ECM program (see section C);
   b. Requiring nursing facility level of care services based on assessment;
   c. Willing and able to receive medically necessary nursing facility level of care services at an assisted living facility in lieu of a nursing facility.

APPENDIX B: CLFP CASELOAD

Agency	Specialty	Average Caseload per Care Manager
Institute on Aging	Program and case management supervision, 8 FTEs city-wide intensive Care Managers	17–22 intensive cases
IOA Subcontractors:		
Catholic Charities CYO	1 Care Coordinator	30-40 cases
Conard House	1 Money Management Care Manager	40-50 cases
Self Help for the Elderly	1 Care Manager/Social Worker	17-22 intensive cases