

Community Supports Member Referral Form

Housing Insecurities

General referral information

Kaiser Permanente **ONLY** accepts referrals for **Medi-Cal Members** whose coverage is assigned to Kaiser Permanente.

Kaiser Permanente employs a “No Wrong Door” approach for Enhanced Care Management (ECM), Complex Case Management (CCM), Community Health Worker (CHW), and Community Supports (CS) referrals – referrals should be submitted to the Member’s Managed Care Plan (MCP) and will be accepted from all points of care within the continuum. While KP employs a “No Wrong Door” approach for Community Supports, Medi-Cal Members must meet specific criteria, and all required documentation for the requested Community Support must be completed and submitted before the referral can be reviewed.

What are Community Support services?

CS services improve the health and well-being of MCP Members by addressing Members’ health-related social needs and helping them live healthier lives and avoid higher, costlier levels of care. They are non-medical services (e.g., housing navigation, asthma remediation) provided as cost-effective alternatives to traditional medical services and settings. CS availability varies by county.

Time-limited coverage of housing-related CS services are intended to help Members experiencing or at risk of homelessness address their health-related social needs, support their transition to housing stability, and realize the significant improvements in health that have been shown to result from stable housing.

Which Community Support services are included in this referral form?

- [Housing Transition Navigation Services](#)
- [Housing Deposits](#)
- [Housing Tenancy and Sustaining Services](#)
- [Day Habilitation Programs](#)
- [Recuperative Care \(Medical Respite\)](#)
- [Short-Term Post-Hospitalization Housing](#)
- [Transitional Rent](#)

Instructions

Complete all required fields to the best of your ability and submit this form via secure email to the appropriate region. Incomplete or outdated forms may cause processing delays. The most updated referral forms can be found on the Provider Portal.

	Northern California	Southern California
Email Referrals	REGMCDURNS-KPNC@KP.org	RegCareCoordCaseMgmt@KP.org
Provider Portal	NCAL - Provider Portal	SCAL - Provider Portal

SECTION A

Fields marked with an asterisk (*) are mandatory

Is the person being referred a Kaiser Permanente (KP) Medi-Cal Member?*

- Yes, this is a Kaiser Permanente Medi-Cal Member
 No, STOP, do NOT proceed. Please send referral to their assigned Medi-Cal Managed Care Plan

Referral Source Information

Date of Referral*	Referrer Name*
Referring Organization Name*	
Referring Organization National Provider Identifier (NPI)*	
Referrer/Referring Organization Address* (Street, City, State, Zip Code)	
Referrer Email*	Referrer Phone Number*
Referrer Relationship to Member? Select the <u>ONE</u> that applies*: <input type="checkbox"/> Medical provider <input type="checkbox"/> Social services provider <input type="checkbox"/> Member/family <input type="checkbox"/> Other please specify:	
External referral by? Select the <u>ONE</u> that applies*: <input type="checkbox"/> Network Lead Entity (NLE) <input type="checkbox"/> ECM, CHW or CS vendor – select the one you are affiliated with: <input type="checkbox"/> Full Circle Health <input type="checkbox"/> Independent Living Systems <input type="checkbox"/> Partners in Care <input type="checkbox"/> Foodsmart <input type="checkbox"/> Mom's Meals <input type="checkbox"/> Managed Care Plan (MCP) <input type="checkbox"/> Other health care provider <input type="checkbox"/> Mental health care provider <input type="checkbox"/> Hospital or Emergency Room care team <input type="checkbox"/> County or other government organization <input type="checkbox"/> Schools/Local Education Agencies (LEAs) <input type="checkbox"/> Other community-based provider <input type="checkbox"/> Legal aid organizations <input type="checkbox"/> Justice involved organizations <input type="checkbox"/> Other, please specify:	

SECTION A

Fields marked with an asterisk (*) are mandatory

Member Information

Member Name (First Name, Middle Initial, Last Name)*	
Member Date of Birth *	Member Phone Number *
Member Mailing Address * (Street, City, State, Zip Code)	
Member's Kaiser Permanente MRN * (or Medi-Cal CIN if MRN is unknown)	
Caregiver/Support Person Name	
Caregiver/Support Person Contact (Email/Phone Number)	

Current Service Usage

1.) Is the Member currently receiving any of the following services? Select ALL that apply:

A.) ECM – If selected, please include the following information:

Provider Name: _____

Email or Phone Number: _____

B.) CCM

C.) CHW

D.) CS Services

<input type="checkbox"/> Respite Services (Caregiver Respite) <input type="checkbox"/> Assisted Living Facility Transitions <input type="checkbox"/> Community or Home Transition Services <input type="checkbox"/> Personal Care and Homemaker Services <input type="checkbox"/> Environmental Accessibility Adaptations (Home Modifications) <input type="checkbox"/> Medically Tailored Meals/Medically-Supportive Food <input type="checkbox"/> Sobering Centers	<input type="checkbox"/> Asthma Remediation <input type="checkbox"/> Housing Transition Navigation Services <input type="checkbox"/> Housing Deposits <input type="checkbox"/> Housing Tenancy and Sustaining Services <input type="checkbox"/> Day Habilitation Programs <input type="checkbox"/> Recuperative Care (Medical Respite) <input type="checkbox"/> Short-Term Post-Hospitalization Housing <input type="checkbox"/> Transitional Rent
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SECTION A

Fields marked with an asterisk (*) are mandatory

Homeless Attestation*

By checking this box, you confirm that Member meets the Department of Housing and Urban Development (HUD) definition of homeless or at risk of experiencing homelessness AND that you can provide supporting documentation if requested.

- [HUD definition of homelessness](#)
- [HUD definition of at risk of homelessness](#)

Attestation*

By checking this box, you confirm that all information provided on this form is accurate and has been verified. You also confirm that the Member has consented to participate in the program(s) to which they are being referred and that you can provide supporting documentation if requested.

SECTION B: Community Support Services

1. Housing Transition Navigation

Important Information – Please Read

- **Description:** Assist Members with finding, applying for, and obtaining housing.
- **Key Information:**
 1. Services do not include the provision of Room and Board or payment of rental assistance.
 2. Actions to be taken under HTNS must be identified as reasonable and necessary in the Member's housing support plan.
 3. Service duration can be as long as necessary and there is no limit on how many times an eligible Member may be authorized for this service.
 4. While it is appropriate and optimal for Members to receive HTNS prior to Housing Deposits and/or Transitional Rent, it is not a prerequisite.

1.1) TO BE ELIGIBLE, THE MEMBER MUST MEET ONE OF THE FOLLOWING CRITERIA.

- A)** Member meets the following social **AND** clinical risk factor requirement.
- Social Risk Factor Requirement:** Member meets the HUD definition of [homelessness](#) or [at-risk of homelessness](#). →Select the one that applies:
- Homelessness
 - At-risk of homelessness
- Clinical Risk Factor Requirement:** Member must have one or more of the following qualifying clinical risk factors. →Select all that apply:
- Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
 - Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
 - One or more serious chronic physical health conditions;
 - One or more physical, intellectual, or developmental disabilities; or
 - Individuals who are pregnant up through 12-months postpartum.
- OR**
- B)** Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS.
- OR**
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to
- C)** use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

COMMENTS (optional)

SECTION B: Community Support Services

2. Housing Deposits (Page 1 of 4)

Important Information – Please Read

- **Description:** Assist Members with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household.
- **Key Information:**
 1. Services do not include the provision of Room and Board or payment of rental assistance.
 2. Housing Deposits are available once per demonstration period (on average, every 5 years).
 3. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them if a Member has already received Housing Deposits once within the demonstration period.
 4. DHCS is no longer requiring a Member to receive the Community Supports HTNS as a condition of receiving Housing Deposits.
 5. All Members who receive Housing Deposits are required to have a housing support plan.
 6. All services and goods related to Housing Deposits must be identified as reasonable and necessary in the Member's housing support plan.

2.1) TO BE ELIGIBLE, THE MEMBER MUST MEET ONE OF THE FOLLOWING CRITERIA.

- A)** Member meets the following social **AND** clinical risk factor requirement.
Social Risk Factor Requirement: Member meets the HUD definition of [homelessness](#) or [at-risk of homelessness](#). →Select the one that applies:
 - Homelessness
 - At-risk of homelessness**Clinical Risk Factor Requirement:** Member must have one or more of the following qualifying clinical risk factors. →Select all that apply:
 - Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
 - Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
 - One or more serious chronic physical health conditions;
 - One or more physical, intellectual, or developmental disabilities; or
 - Individuals who are pregnant up through 12-months postpartum.

OR
- B)** Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS.

OR

Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to
- C)** use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

SECTION B: Community Support Services

2. Housing Deposits (Page 2 of 4)

2.2) WHICH OF THE FOLLOWING ONE-TIME EXPENSES IS THE MEMBER REQUESTING?

→ Select all items that apply:

List the estimated one-time expenses e.g., Application fee \$50, Security deposit \$1800

Application fee:

Security deposit:

Set up fees/deposits or first month's coverage for utilities or service access:

First month coverage of utilities

Services necessary for the individual's health and safety:

Adaptive aids designed to preserve an individual's health and safety in the home:

Home goods:

2.3) WHAT IS THE TOTAL COST OF HOME GOODS THE MEMBER REQUESTING?

Please attach a pre-purchase itemized breakdown of the requested items along with your submission.

\$

Examples of approved home goods items:	
Kitchen	Bowls, cutlery, dish towels, pots and pans, sponges, dishwasher, cups/glasses, cutting boards, utensils, soap, oven, can opener, dining table/chairs, microwave, placemats, cleaning supplies, dish drying rack, plates, place setting, salt/pepper shakers
Bedroom	Bedframe, mattress, bedding, clothes hangers, infant furniture, nightstand, hypoallergenic mattress cover, pillow covers
Bathroom	Bathmat, soap dish, shower/bath curtains, toiletries, towels, trash can, toothbrush holder, cleaning supplies
Living room	Vouch, lamps/lighting, coffee/end tables
Other	Air conditioners, air filters, heater, cleaning supplies, medically necessary adaptive aids, night lights, vacuum cleaner, smoke detectors, carbon monoxide detectors

SECTION B: Community Support Services

2. Housing Deposits (Page 3 of 4)

Housing goods pricing guidance:	
Goods	Maximum
Air Conditioner	\$250 (one per household)
Bed Frame	\$200 (per bed frame)
Heater	\$100 (one per household)
Mattress	\$350 (per mattress)
Microwave	\$125 (one per household)
Dining Table and chairs	\$300
Couch	\$500 (one per household)
Infant Furniture	\$300
General Home Goods (i.e. bathroom kit, kitchen, bedroom)	\$300 (i.e. basic home necessities such as supplies for bathroom, kitchen, bedroom)

Additional Guidance on Refrigerator

Assembly Bill 628 ([AB-628](#)) requires a landlord to provide a refrigerator that is maintained in good working order and is capable of safely storing food. AB-628 also authorizes a tenant and landlord to mutually agree when the lease is signed if the tenant chooses to provide and maintain their own refrigerator.

The lease must contain a statement in substantially the following form:

“Under state law, the landlord is required to provide a refrigerator in good working order in your unit. By checking this box, you acknowledge that you have asked to bring your own refrigerator and that you are responsible for keeping that refrigerator in working order.”

When the above requirement is met, Kaiser Permanente will review the request and make a determination.

Additional Guidance on Refrigerator and Stove

Assembly Bill 628 ([AB-628](#)) updates California’s tenantable standards by adding a working refrigerator and stove to the list of required features that residential buildings and dwelling units must maintain in order to be considered habitable.

Units **exempt** from the updated standards, include:

- **Permanent supportive housing,**
- **Single-room occupancy units with shared kitchens,**
- **Residential hotel units,** and
- Units within facilities with **communal kitchen spaces**

COMMENTS (optional)

SECTION B: Community Support Services

2. Housing Deposits (Page 4 of 4)

REQUIRED DOCUMENTS FOR ALL SERVICES

- Housing Support Plan (HSP):** The following elements must be included in the Member's HSP
 - A permanent housing strategy for the Member, including:
 - The payment sources and mechanisms (e.g., Member's income, BHSA Housing Interventions, or other long-term subsidies)
 - The full range of permanent housing supports that will support the Member in sustaining tenancy (e.g., tenancy sustaining service, utilities)
 - Incorporate barriers identified in the Member's housing assessment, both short- and long-term measurable goals for each barrier and the Member's strategy for achieving those goals
 - The service(s) requested must be identified as reasonable and necessary and clearly documented
 - The Members' preferences and needs
- Income Verification Source(s)**
 - Income verification documents should be current/recent
 - One month for consistent income and up to three months for inconsistent income

Services Requested	Supporting documents to be collected by NLE
<input type="checkbox"/> Application fee request	\$300 max per member <i>Note: Copy of filled out application(s) with fee noted must be kept in the member's record for auditing purpose</i>
<input type="checkbox"/> Security deposit	<input type="checkbox"/> Signed lease agreement with the Member's name, security deposit amount and move-in date. The lease can be unsigned if the Member has not moved in. <i>Note: Member's rent must fall within 30% to 70% of the Member's monthly income.</i>
<input type="checkbox"/> Set up fees/deposits for utilities or services access and one-month payment in utility arrears <input type="checkbox"/> First month coverage of utilities, (including but not limited to telephone, gas, electricity, heating, and water)	<i>Note: Copy of utility bill must be kept in the member's record for auditing purpose</i>
<input type="checkbox"/> Services necessary for the individual's health and safety (pest eradication, one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality standards, or other habitability standards, as applicable, where those costs are not the responsibility of the landlord under applicable law)	<i>Note: Copy of invoice/receipt must be kept in the member's record for auditing purpose</i>
<input type="checkbox"/> Adaptive aids designed to preserve an individual's health and safety in the home (hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member)	<i>Note: Copy of invoice/receipt must be kept in the member's record for auditing purpose</i>
<input type="checkbox"/> Essential household items and furnishings	<input type="checkbox"/> Pre-purchase: Itemized breakdown of costs <i>Note: Itemized lists and receipts must be kept in the Member's record for auditing purpose. Delivery fees are allowable and will count toward the overall \$5,000 cap</i>

SECTION B: Community Support Services

3. Housing Tenancy and Sustaining Services

Important Information – Please Read

- **Description:** Supports Member in maintaining safe and stable tenancy once housing is secured.
- **Key Information:**
 1. Services do not include the provision of Room and Board.
 2. These services must be identified as reasonable and necessary in the Member's housing support plan.
 3. Many individuals will have also received Housing Transition/Navigation services (at a minimum, a housing assessment and housing support plan) before this service, but it is not a prerequisite for eligibility.

3.1) TO BE ELIGIBLE, THE MEMBER MUST MEET ONE OF THE FOLLOWING CRITERIA.

- A)** Member meets the following social **AND** clinical risk factor requirement.
- Social Risk Factor Requirement:** Member meets the HUD definition of [homelessness](#) or [at-risk of homelessness](#). →Select the one that applies:
- Homelessness
 - At-risk of homelessness
- Clinical Risk Factor Requirement:** Member must have one or more of the following qualifying clinical risk factors. →Select all that apply:
- Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
 - Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
 - One or more serious chronic physical health conditions;
 - One or more physical, intellectual, or developmental disabilities; or
 - Individuals who are pregnant up through 12-months postpartum.
- OR**
- B)** Individuals who are determined eligible for Transitional Rent. These individuals are automatically eligible for HTNS.
- OR**
- C)** Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration.

3.2) MEMBER MOVE-IN DATE:

COMMENTS (optional)

SECTION B: Community Support Services

4. Day Habilitation Programs (Page 1 of 2)

Important Information – Please Read

- **Description:** Assists Members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.
- **Key Information:**
 1. While receiving Day Habilitation Program services, Members needing housing-related support should be referred for the appropriate Housing Trio services.
 2. Program services are available for as long as necessary. Services can be provided continuously, or through intermittent meetings, in an individual or group setting.

4.1) The Member **MUST** meet **ONE** of the following criteria.

→Select the one that applies:

A) Member is experiencing homelessness;

OR

B) Member exited homelessness (no longer homeless) and entered housing in the last 24 months;

OR

C) Member at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program

4.2) **WHAT TYPE OF TRAININGS IS THE MEMBER INTERESTED IN RECEIVING?**

→Select all that apply:

The use of public transportation

Personal skills development in conflict resolution

Community participation

Developing and maintaining interpersonal relationships

Daily living skills (cooking, cleaning, shopping, money management)

Community resource awareness such as police, fire, or local services to support independence in the community

SECTION B: Community Support Services

4. Day Habilitation Programs (Page 2 of 2)

4.3) WHICH ASSISTANCE PROGRAMS IS THE MEMBER INTERESTED IN RECEIVING?

→Select all that apply:

- Selecting and moving into a home (The Member should be referred to HTNS)
- Locating and choosing suitable housemates
- Locating household furnishings (The Member should be referred to HD)
- Settling disputes with landlords (The Member should be referred to HTSS)
- Managing personal financial affairs
- Refer to the Housing Transition/Navigation Services CS
- Refer to the Housing Tenancy and Sustaining Services CS
- Referral to non-CS housing resources if Member does NOT meet Housing Transition/Navigation Services eligibility criteria
- Recruiting, screening, hiring, training, supervising, and dismissing personal attendants
- Dealing with and responding appropriately to governmental agencies and personnel
- Asserting civil and statutory rights through self-advocacy
- Building and maintaining interpersonal relationships, including a circle of support
- Coordinating with MCP to link the Member to any Community Support services and/or ECM
- Providing a referral to non-Community Supports housing resource if the Member does not meet the eligibility criteria for HTN, Housing Deposits, HTSS, or Transitional Rent
- Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if Member is NOT receiving these services through CS or ECM
- Coordination with Medi-Cal managed care plan to link Member to healthcare, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or ECM

COMMENTS (optional)

SECTION B: Community Support Services

5. Recuperative Care (Medical Respite)

Important Information – Please Read

- **Description:** Assists Members who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including a behavioral health condition).
- **Key Information:**
 1. For Recuperative Care, the Member will need to be placed in a Kaiser Permanente contracted facility prior to submitting the referral (this form).
 2. Recuperative Care cannot exceed a duration of six months per rolling 12-month period (but may be authorized for a shorter period based on individual needs) and is subject to the six-month global cap on Room and Board services.
 3. Facility operators and their employed staff providing Recuperative Care that are not licensed as Community Care Facilities may not directly assist Members with ADLs or IADLs.
 4. For Members requiring ADL/IADL support in these facilities, MCPs may coordinate the concurrent delivery of Personal Care and Homemaker Services (see Personal Care and Homemaker Services Community Support in Community Supports Policy Guide Volume 1) or contract with a licensed third-party provider to furnish these services.
 5. While receiving Recuperative Care services, Members should be offered Housing Transition/Navigation services.

5.1) IS THIS A STREAMLINED AUTHORIZATION REQUEST?

Question 5.1 - To be completed by the Network Lead Entities or Recuperative Care Facility

- No
- Yes (If selected, please include the information below)

Facility Name:

Service Start Date:

5.2) TO BE ELIGIBLE, THE MEMBER MUST MEET **BOTH** OF THE FOLLOWING CRITERIA:

- Member requires recovery in order to heal from an injury or illness
- AND**
- Member meets the HUD definition of experiencing or at risk of homelessness

COMMENTS (optional)

SECTION B: Community Support Services

6. Short-Term Post-Hospitalization Housing (Page 1 of 2)

Important Information – Please Read

- **Description:** Provides post-hospitalization housing provides Members who are exiting an institution and experiencing or at risk of homelessness with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting the institution.
- **Key Information:**
 1. The Member will need to be placed in a Kaiser Permanente contracted facility prior to submitting the referral (this form).
 2. While receiving Short Term Post Hospitalization Housing, Members should be offered Housing Transition/Navigation services.
 3. Short-Term Post Hospitalization Housing cannot exceed a duration of six months per rolling 12-month period and is subject to the six-month global cap on Room and Board services.

6.1) THE MEMBER MUST MEET ALL OF THE FOLLOWING CRITERIA:

- A)** Member is exiting one of the following: 1) Recuperative Care Facilities (includes facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), 2) Inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), 3) Residential substance use disorder or mental health treatment facility, 5) Correctional Facility, or 6) Nursing facility.

AND

- B)** Member meets the HUD definition of experiencing or at risk of homelessness

AND

- C)** Member meets one of the following criteria below

→ Select the one that applies:

- 1.)** Is receiving ECM
- 2.)** Has one or more serious chronic conditions
- 3.)** Has a serious mental illness
- 4.)** Is at risk of institutionalization
- 5.)** Is requiring residential services as a result of substance use disorder

AND

- D)** Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post Hospitalization Housing

6.2) EXITING INSTITUTION INFORMATION:

Facility Name:

Facility Type:

Expected Discharge Date:

SECTION B: Community Support Services

6. Short-Term Post-Hospitalization Housing (Page 2 of 2)

COMMENTS (optional)

SECTION B: COMMUNITY SUPPORT SERVICES

□ 7. Transitional Rent (Page 1 of 5)

Important Information – Please Read

- **Description:** Transitional Rent provides up to six months of rental assistance and is **ONLY** available to the Behavioral Health population of focus (PoF). Medi-Cal Members must meet specific criteria, and all required documentation must be completed and submitted before the referral can be reviewed.
- **Key Information:**
 1. Transitional Rent may be used to cover the following expenses:
 - a. Rental assistance in allowable settings
 - b. Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment
 2. Transitional Rent can provide up to six months of rental assistance every 5 years, subject to the six-month global cap on Room and Board services within a rolling 12-month period. The six months of Transitional Rent are not required to be continuous.
 3. Members who are authorized for Transitional Rent will also be authorized for ECM and the appropriate housing support services.
 4. DHCS requirements:
 - a. MCPs must ensure that a Member has a housing support plan (HSP) in place as a condition for authorizing a Member for Transitional Rent, whether the Member is placed in an interim or permanent setting. The HSP must meet the HSP requirements outlined in the policy guide.
 - b. DHCS requires that settings be compliant with applicable HUD quality standards or habitable as defined by state law.
 - i. Transitional Rent Providers must conduct a basic unit or setting inspection to verify compliance with HUD or state habitability standards.
 - ii. The attestation of compliance, either with the HUD standards or state habitability standards, must be submitted by the Transitional Rent Provider as a condition of authorization.
 5. Transitional Rent is only available for Members who meet the Behavioral Health criteria outlined in subsection A of section 7.1.
 6. Required documentation for Transitional Rent includes:
 - a. Referral Form (this form)
 - b. Updated HSP
 - c. Habitability Attestation (a part of this form)
 - d. Clinical Risk Eligibility Attestation from the County Behavioral Health (if referral is not from the County)
 - e. Income Verification Documents
 - f. Lease Agreement
 - g. Applicable Support Documents

SECTION B: COMMUNITY SUPPORT SERVICES

7. Transitional Rent (Page 2 of 5)

7.1) TO BE ELIGIBLE, THE MEMBER MUST MEET **ALL** OF THE FOLLOWING CRITERIA. SUBJECT TO THE AVAILABLE REMAINING DAYS IN THE GLOBAL CAP.

- A) **Clinical Risk Factor Requirement:** Must have one or more of the following qualifying clinical risk factors. →Select all that apply:
- Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
 - Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS)

AND

- B) **Social Risk Factor Requirement:** Meets the HUD definition of experiencing or at risk of homelessness. →Select the one that applies:
- Experiencing homelessness
 - At-risk of experiencing homelessness

AND

- C) **The Member must meet one of the following transitioning requirements:**
→Select the one that applies:

- 1) **Transitioning Population Requirement: Must be included within one of the following transitioning populations.** →Select the one that applies:
- Transitioning out of an institutional or congregate residential setting:** Member transitioning out of an institutional or congregate residential setting, including but not limited to an inpatient hospital stay, an inpatient or residential substance use disorder treatment facility, an inpatient or residential mental health facility, or nursing facility.
 - Transitioning out of a carceral setting:** Member transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been in custody and held involuntarily through operation of law enforcement authorities.
 - Transitioning out of interim housing:** Member transitioning out of transitional housing, rapid rehousing, a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing, whether funded or administered by HUD, or at the State or local level.
 - Transitioning out of recuperative care or short-term post-hospitalization housing:** Member transitioning out of short-term post-hospitalization housing or recuperative care, whether the stay was covered by Medi-Cal managed care, or another source.
 - Transitioning out of foster care:** Member having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.

OR

- 2) **Experiencing unsheltered homelessness:** Member or families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

OR

- 3) **Eligible for Full-Service Partnership (FSP):** FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.

SECTION B: COMMUNITY SUPPORT SERVICES

7. Transitional Rent (Page 3 of 5)

7.2) OTHER SERVICES

A) Has the Member received Transitional Rent (TR) services from Kaiser Permanente or another Medi-Cal Managed Care Plan?

Yes

Medi-Cal Managed
Care Plan Name:

Service Start Date:

Service End Date:

No

B) Has the Member received Recuperative Care services from Kaiser Permanente or another Medi-Cal Managed Care Plan?

Yes

Medi-Cal Managed
Care Plan Name:

Service Start Date:

Service End Date:

No

C) Has the Member received Short-Term Post-Hospitalization services from Kaiser Permanente or another Medi-Cal Managed Care Plan?

Yes

Medi-Cal Managed
Care Plan Name:

Service Start Date:

Service End Date:

No

SECTION B: COMMUNITY SUPPORT SERVICES

7. Transitional Rent (Page 4 of 5)

7.3) HOUSING UNIT DETAILS

Setting Type and Details → Select one of the options below:

A) Interim Setting: When a Member has their own room

- Efficiency
- One-bedroom
- Two-bedroom
- Three-bedroom
- Four-bedroom

B) Interim Setting: With a small number of individuals per room

- One bed occupied where *two beds available*
- One bed occupied where *three beds available*
- One bed occupied where *four beds available*
- Two beds occupied where *two beds available*
- Two beds occupied where *three beds available*
- Two beds occupied where *four beds available*
- Three beds occupied where *three beds available*
- Three beds occupied where *four beds available*
- Four beds occupied where *four beds available*

C) Interim Setting: Hotel / Motel

- Hotel / motel

D) Permanent Setting: Allowable Permanent Setting (not SRO)

- Efficiency
- One-bedroom
- Two-bedroom
- Three-bedroom
- Four-bedroom

E) Permanent Setting: Single Room Occupancy (SRO)

- Single Room Occupancy (SRO)

F) Permanent Setting: Shared housing where two or more people live in one rental unit

- One bedroom in shared *two-bedroom*
- One bedroom in shared *three-bedroom*
- One bedroom in shared *four-bedroom*
- Two-bedroom in shared *three bedroom*
- Two-bedroom in shared *four bedroom*
- Three-bedroom in shared *four bedroom*

SECTION B: COMMUNITY SUPPORT SERVICES

7. Transitional Rent (Page 5 of 5)

7.4) HOUSEHOLD SIZE

→Select the one that applies:

- Single Adult Member
- Adult Member & Family
- Minors and Family
- Single Minor Member
- Adult Member with Partner/Spouse (No children)
- Adult Member with Other Occupant(s) (Non-Family)
- Minor Members with Other Occupant(s) (Non-Family)

7.5) MEMBER UNIT PLACEMENT INFORMATION

Unit Placement Zip Code:

Unit Placement County:

7.6) HABITABILITY ATTESTATION*

By checking this box, I attest that the unit has been inspected and is in compliance with HUD quality standards or habitability as defined by state law.

TR Provider Name:

TR Provider Title:

Affiliated Agency:

Phone/Email:

Transitional Rent Provider Signature

Date

TRANSITIONAL RENT REFERRAL CHECKLIST

To avoid delays in the decision-making process for the Members Transitional Rent referral, please ensure the information provided is sufficient and that ALL the following are included in the submission.

- Referral Form (this document)
- Updated Housing Support Plan
- Habitability Attestation (see above on this form)
- Clinical Risk Eligibility Attestation from the County Behavioral Health (if referral is not from the County)
- Lease Agreement
- Income Verification Documents
- Applicable Supporting Documents

To ensure the Member's monthly rent aligns with market standards, see HUD's Fair Market Rents available here: <https://www.huduser.gov/portal/datasets/fmr.html>

COMMENTS (optional)

STOP! PLEASE READ BEFORE SUBMITTING

Complete all required fields to the best of your ability and submit this form via secure email to the appropriate region. Incomplete or outdated forms may cause processing delays. The most updated referral forms can be found on the Provider Portal.

	Northern California	Southern California
Email Referrals	REGMCDURNS-KPNC@KP.org	RegCareCoordCaseMgmt@KP.org
Provider Portal	NCAL - Provider Portal	SCAL - Provider Portal