

Housing Transition and Tenancy Referral Form

Housing Transition Navigation Services (HTNS) & Housing Tenancy Sustaining Services (HTSS) assist members with obtaining and/or sustaining housing. HTNS includes housing assessment, housing support plan and assistance securing housing. HTSS goal is to maintain safe and stable tenancy once housing is secured.

For criteria information review: [Housing Transition Navigation Services](#) And [Housing Tenancy and Sustaining Services](#)

<u>Request Type</u>			
<input type="checkbox"/> Housing Transition Navigation Services		<input type="checkbox"/> Housing Tenancy and Sustaining Services	
<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension	<input type="checkbox"/> Member consented to housing referral.	
Member's First Name:	Last Name:	Phone Number:	IEHP Number:
Member's Address:		DOB:	Priority:
			<input type="checkbox"/> Standard <input type="checkbox"/> Expedited
Diagnosis (Serious chronic condition or serious mental health diagnosis):		ICD-Code:	
<u>Eligibility Criteria</u>			
Housing Transition Navigation Services and Housing Tenancy Sustaining Services, Member must meet the following:			
<input type="checkbox"/> Experiencing or at risk of homelessness			
And <u>Must have ONE or MORE</u> of the following qualifying clinical risk factors:			
<input type="checkbox"/> Meet the access criteria for Medi-Cal Specialty Mental Health Services (SMHS) <input type="checkbox"/> Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) <input type="checkbox"/> One or more serious chronic physical health conditions <input type="checkbox"/> One or more physical, intellectual or developmental disabilities <input type="checkbox"/> Individuals who are pregnant up through 12-months postpartum			
OR			
<input type="checkbox"/> Individuals who are determined eligible for Transitional Rent. <input type="checkbox"/> Individuals who are prioritized for permanent housing unit or rental subsidy through CES or similar program			
<i>Please note, if boxes are NOT checked, STOP. Members do not meet eligibility criteria.</i>			
<u>Additional Information:</u>			
Please submit the following documents with referral form:			
<input type="checkbox"/> Individualized Housing Support Plan attached <input type="checkbox"/> Documentation supporting Member's chronic condition, from treating Primary Care Physician/Specialist or Mental Health Provider, is serious and debilitating <input type="checkbox"/> Documentation supporting Member's mental illness, from treating Primary Care Physician/Specialist or Mental Health Provider, is serious and debilitating. <input type="checkbox"/> For extensions please submit any progress notes and/or documentation identifying progress done within the last approved period			
<i>Please submit any additional supporting documentation with the referral form.</i>			

**This Request Does Not Guarantee Eligibility. Check Eligibility Prior to Rendering Service.
Payment Will Not Be Made For Unauthorized Services.**