MOLINA HEALTHCARE

Community Supports
Housing Tenancy and Sustaining Services
VERSION 3

Housing Tenancy and Sustaining Services support individuals in maintaining stable housing through early intervention, education, landlord mediation, advocacy, and crisis planning. Eligible individuals must be enrolled in Medi-Cal and meet specific criteria outlined at the end of this form.

Send this completed referral form along with the member's Individualized Housing Support Plan (IHSP) and supporting documentation via fax to (800) 811-4804.

***The form must be completed in its entirety to be valid. Incomplete forms will not be processed. ***

CS Service Information: *		
Referral Date:		
Referral Type:	Select One	
Please describe "Other" referral type:		
CS Service Code:	☐ **T2041** – Support brokerage, self-directed (U6) – Use for ongoing coordination and housing stability support.	
Disclaimer: Providers must request HCPCS codes as specified in their Community Supports (CS) contract with Molina Healthcare. Requests for non-contracted codes may result in processing delays or denial.		
CS Service Start Date:	Referrals are valid for 90 days.	
Request Type:	☐ Initial Request	☐ Reauthorization Request **MM/YY of Initial Enrollment into Housing Tenancy:**

Requestor Information: *	
Referrer:	☐ Hospital/SNF ☐ PCP/Clinic ☐ IPA ☐ ECM ☐ Molina CM ☐ Other:
Referrer Organization Name:	
Referring Organization NPI:	.
Referrer Name:	.
Referrer Title:	.
Referrer Phone Number:	
Referrer Email:	
Fax Number:	

Member Information: *
Member Name:
DOB:
Medi-Cal ID/CIN:
Preferred Language:
Residential Address:
City:
State:

Zip Code:	
Primary Phone Number:	
Primary Phone Type:	Select One
Secondary Phone Number:	
Secondary Phone Type:	Select One
Alternate Contact Name:	
Alternate Contact Phone #:	
Last Member Contact:	
Date Member Housed:	

Guardian/Conservator Information (if applicable)	
Guardian First Name:	**Guardian Last Name:**
Guardian Phone Number:	

Member Eligibility

Enrollment Status:

☐ Only Medi-Cal ☐ Partial Duals Only: Medi-Cal with Medicare Part B and/or D

Does the Member meet the following social and clinical risk factor requirements?

Experiencing or at risk of experiencing homelessness *and:*

- ☐ Meets the access criteria for Specialty Mental Health Services (SMHS)
- ☐ Meets the access criteria for DMC or 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.
- ☐ None of the above apply

Has the Member been 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 serios chronic conditions and/or serious mental illness, institutionalization or requiring residential services because of a substance use disorder and/or is exiting incarceration?

- ☐ **YES**
- ☐ **NO**

☐ **The Individualized Housing Support Plan is attached, detailing documented needs (Required for renewals).**

Is the Member currently receiving Housing Transition Navigation Services?

☐ Yes

☐ No

Organization who developed the Individualized Housing Support Plan:

Housing Acuity Index (check all that apply):

(Individualized Housing Support Plan is required for all renewal requests and must address any items checked below)
A. Housing Stability Risk
☐ Currently Homeless (living on the streets, shelter, or place not meant for habitation)
☐ Imminent Risk of Homelessness (facing eviction within 14 days, staying with friends/family temporarily)
☐ Housing Instability (multiple moves in past 12 months, at risk of losing current housing)
☐ Stable Housing with Support Needed (requires assistance for lease compliance, landlord mediation, rental assistance)
B. Medical & Social Vulnerability
☐ Serious Mental Illness (SMI) or Substance Use Disorder (SUD)
☐ Chronic Physical Health Condition impacting daily life
☐ Disability or Mobility Impairment requiring housing modifications
☐ History of Hospitalizations or ER Visits related to housing instability
☐ History of Domestic Violence or Trauma
☐ Limited Support System (little to no family/friend assistance)
C. Service Needs & Barriers to Housing Stability
☐ Eviction Notice / Lease Violation
☐ Unpaid Rent or Utilities causing risk of eviction
☐ No Income or Insufficient Income to sustain rent
☐ Difficulty Managing Medications or Health Needs
☐ Lack of ID or Required Documents for housing applications
☐ Criminal Background or Prior Evictions affecting eligibility

Required Attestations: *
☐ I attest the Member or Member's Authorized Representative consented to Housing Tenancy and Sustaining Services.
☐ I attest that these services are provided as part of a care plan to support housing stability and not for general housing assistance alone.

Individualized Housing Support Plan (IHSP) – Renewal Supplement

Required for ALL Housing Tenancy and Sustaining Services (HTSS) Re-authorization/Renewal Requests

Attach this completed worksheet to the HTSS referral form for all reauthorization/renewal requests. The plan must reflect progress made, barriers addressed, and proposed goals for the next 90-day period, aligned with the original eligibility criteria.

Member Name:	**Member Medi-Cal CIN:**
Renewal Type: Select One	

Summary of Services Provided During Initial HTSS Period (Required)

(Examples: landlord communication, utility assistance, budgeting support, care coordination, IHSS linkage, etc.)

Member Progress on Previous Goals (Check all that apply)

(Indicate the status of each planned goal for the previous 90-day period. Provide a brief note for goals In Progress and/or Not Met.

Prior Goal Category	Goal Met	In Progress	Not Met	Explanation
Behavioral Risk Monitoring	☐	☐	☐	
Tenant Rights Education	☐	☐	☐	
Fair Housing Training	☐	☐	☐	
Relationship Coaching	☐	☐	☐	

Landlord Coordination	☐	☐	☐	
Dispute Resolution Support	☐	☐	☐	
Eviction Prevention Resources	☐	☐	☐	
Benefits Advocacy Support	☐	☐	☐	
Recertification Assistance	☐	☐	☐	
Crisis Plan Updates	☐	☐	☐	
Lease Compliance Support	☐	☐	☐	
Health & Safety Checks	☐	☐	☐	
Crisis Intervention Services	☐	☐	☐	
Independent Living Skills	☐	☐	☐	

Planned Support Focus – Next 90 Days

(List the specific goals the provider and member will work toward during the next 90-day authorization period)

Molina recommends using the SMART goals as outlined below:

The SMART acronym can help us remember these components.

Specific: The goal should identify a specific action or event that will take place.
(Who? What? Where? When? Why?)

Measurable: The goal and its benefits should be quantifiable.
(How many? How much?)

Achievable: The goal should be attainable given available resources.
(Can this really happen? Attainable with enough effort? What steps are involved?)

Realistic: The goal should require you to stretch some but allow the likelihood of success.
(What knowledge, skills, and abilities are necessary to reach this goal?)

Timely: The goal should state the time period in which it will be accomplished.
(Can I set fixed deadlines? What are the deadlines?)

Goal Category	New SMART Goal	Target Date	Responsible Party
Select One			☐ Member ☐ Housing Navigator/Specialist
Select One			☐ Member ☐ Housing Navigator/Specialist
Select One			☐ Member ☐ Housing Navigator/Specialist
Select One			☐ Member ☐ Housing Navigator/Specialist
Select One			☐ Member ☐ Housing Navigator/Specialist

Justification for Continued HTSS Services

Briefly explain why the member continues to require tenancy support. Include any remaining risk factors, vendor capacity gaps, or unresolved housing barriers.

Attestation

☐ I attest that this Individualized Housing Support Plan was developed in good faith and reflects the member's current housing stability risks and goals.

☐ I understand that future renewals must demonstrate measurable progress or evolving needs aligned with DHCS eligibility criteria.

☐ The member participated in the development of this Individualized Housing Support Plan and consents to its implementation as part of their care plan.

If the member was unable to participate, explain why:

_____

Attach to the HTSS Referral Form. Do not submit as a standalone document.