

Housing Tenancy and Sustaining Community Supports (CS) provides tenancy and sustaining services to maintain safe and stable residency once housing is secured for members who had been experiencing homelessness and are now newly housed.

Send the completed referral via secure fax to: (800) 811-4804.

Eligibility Criteria:

Molina Enrollment: <input type="checkbox"/> Medi-Cal with Molina	
Member must meet one of the five (5) following criteria:	
(1) <input type="checkbox"/> Member received Housing Transition Navigation Services Community Supports.	
(2) <input type="checkbox"/> Member is prioritized for permanent supportive housing unit or rental subsidy through CES or similar system.	
(3) <input type="checkbox"/> Member meets the HUD definition of homelessness AND one of the following:	
<input type="checkbox"/> Enrolled in ECM.	
<input type="checkbox"/> Have a serious chronic condition, or serious mental illness.	
<input type="checkbox"/> At risk for institutionalization or require residential services as a result of SUD.	
(4) <input type="checkbox"/> Member meets the HUD definition of at risk of homelessness.	
(5) <input type="checkbox"/> Member is at risk of experiencing homelessness AND one of the following:	
<input type="checkbox"/> Have one or more serious chronic condition or serious mental illness.	
<input type="checkbox"/> At risk for institutionalization or require residential services because of SUD or SED.	
<input type="checkbox"/> Enrolled with ECM.	
<input type="checkbox"/> Transition-Age Youth with significant barriers to housing stability.	
<input type="checkbox"/> The Individualized Housing Support Plan is attached which showcases the documented needs.	
Organization who developed the Housing Support Plan:	
Housing Transition Navigation Overlap Timeframe:	<input type="checkbox"/> Yes: If Yes: <input type="checkbox"/> No
<input type="checkbox"/> Member consented to Housing Tenancy referral and acknowledges the once in a lifetime restriction.	

Requestor Information:

Last Member Contact:		Housed Date:	
Referrer: <input type="checkbox"/> Hospital/SNF <input type="checkbox"/> PCP/Clinic <input type="checkbox"/> IPA <input type="checkbox"/> ECM <input type="checkbox"/> Molina CM <input type="checkbox"/> Other:			
Referrer Organization Name:			
Referrer Name:		Title:	
Phone Number:		Referrer Fax Number:	

Member Information:

Member Name:		DOB:	
Medi-Cal ID:		Preferred Language:	
Housing Address:			
Cell Phone Number:			
Alternate Contact Name:		Phone #:	
Tips for Outreach:			

If member has previously received Housing Tenancy and Sustaining Community Supports services, please include information explaining what conditions have changed to demonstrate why the second attempt would be more successful.