Transitional Rent Housing Support Plan

The Housing Support Plan (HSP) should help the member and provider identify strengths and attainable housing-focused goals. A HSP should be updated at least every 180 days and be revised as a member's situation changes and steps are completed, or goals are updated. Please ensure that the form is filled out in its entirety, complete and accurate.

Prepared by: Organization Name: _____ Staff Member Name:_____

Email/Phone: _____ Referral Date: _____ Intake Date: _____ Intake Type: ☐ Phone ☐ In-Person

MEMBER INFORMATION

Member Name: _____ Partnership CIN#: _____ HMIS Client ID (if available): _____

Date of Birth: _____ Gender:____ Phone Number: _____ Email: _____

Primary Language: _____ Preferred form of communication: ☐Phone ☐Email ☐Other: _____

ADDRESS INFORMATION

Street: _____ City: _____ State: ___ Zip Code: _____ County:_____

ELIGIBILITY

Transitional Rent: Eligible high-need members enrolled in a managed care plan may be eligible for up to six months of Transitional Rent if they meet all of the following criteria. Subject to the six-month global cap on room and board services.

1. **Clinical Risk Factor Requirement***: (Must have one or more of the following)*
   - ☐ Meet 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

2. **Social Risk Factor Requirement:**
   - ☐ Experiencing or at risk of homelessness.

AND

3. **Transitioning Population Requirement:** (*Must be included within one of the following transitions populations*)
   - ☐ Transitioning out of an institutional or congregate residential setting
   - ☐ Transitioning out of a carceral setting
   - ☐ Transitioning out of interim housing
   - ☐ Transitioning out of recuperative care or short-term post hospitalization housing
   - ☐ Transitioning out of foster care

OR

- ☐ Experiencing unsheltered homelessness

OR

- ☐ Eligible for Full-Service Partnership (FSP)

Is the member currently enrolled in any of the following programs:

- ☐ Behavioral Health Bridge Housing (BHBH)
- ☐ Behavioral Health Services Act (BHSA)
- ☐ CalWORKS Housing Support Program (HSP)
- ☐ Bringing Families Home (BFH)
- ☐ HomeSafe
- ☐ Housing and Disability Advocacy Program (HDAP)

Has the member utilized Recuperative Care, Short-Term Post-Hopitalization Housing or Transitional Rent with Partnership HealthPlan of California or any other managed care plan once within the demonstration period?

☐ Yes ☐ No ☐ Unsure

If yes, how many total days did the member receive these services? _____
Which health plan(s)? _____

IDENTIFY BARRIERS

Barriers to Housing: Review the list of barriers with the client and complete the action plan to address barriers below. Must identify at least one or more barriers to housing.

- ☐ No rental history
- ☐ Past eviction(s)
- ☐ Doesn't have state / Social Security ID
- ☐ Large family (3+ children)
- ☐ Single parent household
- ☐ Head of household under 18
- ☐ Sporadic employment history
- ☐ No high school diploma / GED
- ☐ Insufficient / no income
- ☐ Insufficient savings
- ☐ No or poor credit history
- ☐ Debts
- ☐ Repeated or chronic homelessness
- ☐ Recent history of substance abuse or actively using drugs or alcohol
- ☐ Recent criminal history
- ☐ Adult or child with mild to severe behavioral problems
- ☐ History of abuse and/or battery but abuser not in the unit
- ☐ Recent or current abuse and/or battering (client fleeing abuser)

Housing Goals and Strategy:

Type of permanent housing the member wishes to obtain after Transitional Rent benefits end:

- ☐ Not applicable because the member will be able to remain in the unit in which they plan to use their Transitional Rent.
- ☐ Their own housing
- ☐ Shared housing
- ☐ Moving in with a family member or friend on a permanent basis
- ☐ Other (please specify): _____

Goal I:			
Target Date:		**☐Member Goal ☐Staff Goal**	
Intervention:			
Barriers:			
Outcomes:	**☐Goal Met ☐Goal Not Met ☐Goal Partially Met**		
Next Steps		**Person Responsible**	**Target Dates**
1. **2.** **3.**			

Goal II:			
Target Date:		**☐Member Goal ☐Staff Goal**	
Intervention:			
Barriers:			
Outcomes:	**☐Goal Met ☐Goal Not Met ☐Goal Partially Met**		
Next Steps		**Person Responsible**	**Target Dates**
1. **2.** **3.**			

Goal III:			
Target Date:		☐**Member Goal** ☐**Staff Goal**	
Intervention:			
Barriers:			
Outcomes:	☐**Goal Met** ☐**Goal Not Met** ☐**Goal Partially Met**		
Next Steps		**Person Responsible**	**Target Dates**
1. **2.** **3.**			

SUPPLEMENTAL SERVICES & BENEFITS

Does the member need supportive services along with Transitional Rent? ☐ Yes ☐ No

Enhanced Care Management (ECM) Information:

Provider Name: _____ Lead Care Manager: _____

Phone Number: _____ Population of Focus: Select from list _____

If the member does **NOT** have an ECM provider, select a reason below:

☐Referred to a provider (Date of referral): _____ ☐Refused services (Date of refusal): _____

Social Factors of Health:

Physical Health: _____ Mental Health: _____

Behavioral Health: _____ Hospitalizations: _____

Community Supports (CS) Information:

☐Housing Transition Navigation Services:

Housing Navigator: _____ Phone Number:_____

☐Housing Deposits:

Housing Navigator: _____ Phone Number:_____

☐Housing Tenancy and Sustaining Services:

Housing Tenancy Provider: _____ Phone Number: _____ Move-in Date: _____

Prior Housing History: ☐Y (please describe in the text box below) ☐N Income Verification: ☐Y ☐N

Other Services: *Please check all that apply.*

☐ Food Security (SNAP/CalFresh, WIC, Food Pantries)
☐ Employment Services (Job training, Resume building)
☐ Peer Support (Mentorship)
☐ Assistance to Access Benefits
☐ Financial Literacy / Budgeting Assistance
☐Utility Support
☐Transportation Assistance
☐In-Home Supportive Services
☐Behavioral or other health care needs
☐Other (please describe): _____

For any of the above-selected supports that the member is not already receiving, please describe any anticipated barriers to securing them and how the member plans to overcome those barriers.

HOUSING PREFERENCES & NEEDS

Note: If a permanent setting, this HSP must be comprehensive. If an interim setting, the Housing Support Plan may be less complete, since identifying a Member's permanent housing strategy / solution and payment source(s) and mechanism(s) can take time for someone in an interim setting.

A member should be housed in a setting that provides the smallest number of bedrooms necessary to house the member's family without overcrowding. Housing choice voucher standard is applied to housing size. (See 24 CFR section 982.402(b).)

Housing Type: ☐ Interim (Requires County BH confirmation of BHSA eligibility. No lease required)
☐ Permanent (Requires Permanent housing strategy and payment mechanism)

Number of adults in households _____ Number of children in households _____

Household Composition:	Preferred Size:	Location:
☐Live alone	☐Studio	☐Close to public transportation ☐Yard or nearby park
☐Live with roommates	☐One bedroom	☐Close to childcare ☐Close to school ☐One level unit
☐Live with Family	☐Two bedroom	☐Desired areas/neighborhoods: _____
☐No Preference	☐Three bedroom	☐Areas/neighborhoods to avoid: _____
☐Other: _____	☐Other: _____	☐Other: _____

Do you or anyone in your household require reasonable accommodation or modification due to a disability? ☐Y ☐N

If yes, please describe accomodations below. Examples could include: An accessible parking space, A grab bar in the bathroom, Modifications to a building policy (e.g., a service animal)

Household: Please list all individuals living in household.

Name of Individual	Date of Birth	Medi-Cal Number (CIN)

Housing Information: The payment provided to Transitional Rent provider is designed to cover the full cost of rent or housing for the member and can only include 1. rental assistance in allowable settings. 2. storage fees, amenity fees and landlord-paid utilities that are charged as part of the rent payment.

Note: If the unit rate exceeds the monthly reimbursable ceiling, the authorization request is subject to denial unless the provider is able to negotiate the rent or temporary housing costs to align with the establish reimbursable limits.

Move-in Date:	**Interim (daily rate): $**	**Permanent (monthly rent): $**
Approved Rent Amount (Internal Use Only):		

SUSTAINABILITY

Employment:

Is the member currently employed? ☐ Yes ☐ No

(*If yes, ask the following questions*):

How many hours did the member work last week? _____ hours

Type of employment: ☐ Permanent ☐ Part-time ☐ Temporary ☐ Seasonal

Current Employer Name: _____Job Title:_____ Address:_____

Previous employment (type and duration): _____

(If no, ask the following questions):
Is the member currently looking for work? ☐Yes ☐ No
Is the member currently unable to work? ☐ Yes ☐ No
(If unable to work, please briefly explain why and how they plan to consistently meet rental obligations.)

Budgeting:

Monthly Income	**Amount**
SSI	
SDI	
Salary	
Rent Subsidy Provided By:_____ Duration: _____	
Pending CalWORKs	
General Assistance	
Other *(please specify)*:	
Total	$ 0.00
Monthly Expenses	**Amount**
Rent	
Utilities	
Other costs *(groceries, transportation, school, etc.)*:	
Total	$ 0.00

What program(s) and/or payment source(s) does the member plan to use to support their permanent housing goal once their Transitional Rent ends? *Select all that apply and please indicate the enrollment status.*

Programs/Payment Sources	Enrollment Status	
	Active	Pending
Behavioral Health Services Act Housing Intervention	☐	☐
Behavioral Health services resource (please specify): _____	☐	☐
Rental assistance program:	☐	☐
Housing voucher (please specify): _____	☐	☐
Rapid rehousing	☐	☐
Permanent supportive housing	☐	☐
State- or locally-funded program (please specify): _____	☐	☐
Shallow subsidy (please specify program/ source): _____	☐	☐
Other (please specify): _____	☐	☐
Assisted living / board and care	☐	☐
Criminal legal system-funded housing program	☐	☐
Public housing	☐	☐
Family reunification assistance program	☐	☐
None / self-pay for housing	☐	☐
Unknown at this time (*only for members in an interim setting.)*	☐	☐
Other (please specify): _____	☐	☐

Sustainability Plan:

Please provide a detailed sustainability plan for the member after the sixth month expiration of Transitional Rent. If the county is providing interventions, how long? Have you secured subsidy?

ADDITIONAL DOCUMENTS

Please check each box and attach the following documents:

☐ CS Referral Form

☐Housing Support Plan (this document)

☐Sustainability Documentation

☐Housing Deposit Request Form

☐Lease / Rental Agreement – Intent to Rent (for permanent settings only)

☐Unit Inspection AND Landlord Engagement

ATTESTATIONS

Transitional Rent Provider:

☐ I certify that all the information provided is true and the member will sustain the dwelling after the 6th month of Transitional Rent is finished.

☐ HSP was developed and reviewed with the member to ensure their housing needs are captured and addressed identified barriers. **Date Reviewed**: _____

☐ This HSP was developed in a way that is culturally appropriate and trauma-informed.

☐ Housing sustainability will be maintained through the use of _____ housing voucher / subsidy.

☐ Habitability statement: I attest to date inspection, and it is in compliance with HUD quality standards or habitability as defined by state law.

_____

Staff Name & Title | Signature | Date

_____

Organization Name | Email | Phone

County Behavioral Health Attestation:

Please check all that apply.

☐ If you selected interim housing, you are attesting that the member will transition to county BHSA housing interventions following Transitional Rent.

☐ This member has been determined to meet eligibility for BHSA within _____ county.

☐ This member has been determined to meet eligibility, but housing sustainability will be maintained through the use of _____ housing voucher/subsidy.

_____

Name | Title | Date

_____

Email | Phone Number | Organization

Member Attestation

☐ I have reviewed the Housing Support Plan and agree with the sustainability plan and goals. I understand that the Transitional Rent Medi-Cal benefit covers 6 months of rent and is only available once in 5 years.

_____

Name | Signature | Date