



**CS Housing Transition Navigation  
All Counties  
Version 2**

**Housing Transition Navigation Community Supports (CS)** assists members experiencing homelessness with obtaining housing by providing support with items such as housing applications, benefits advocacy, securing available resources, and providing help with landlords upon move-in.

**Submit completed form and supporting documentation to the UM Prior Authorization fax (833)305-3130.**

**All fields with an \* are required.**

**SECTION 1 – REFERRAL INFORMATION**

<b>Referral Date</b>	
<b>Referral Type</b>	<input type="checkbox"/> Community Referral <input type="checkbox"/> Identified by Molina <input type="checkbox"/> Self-Referral <input type="checkbox"/> Other:
<b>Referring Organization Name</b>	
<b>Referring Organization NPI</b>	
<b>Referring Individual First Name*</b>	
<b>Referring Individual Last Name*</b>	
<b>Referring Individual Relationship to Member*</b>	
<b>Referring Individual Phone Number*</b>	
<b>Referring Individual Email Address*</b>	

**SECTION 2 – MEMBER INFORMATION**

<b>Member First Name*</b>	
<b>Member Last Name*</b>	
<b>Date of Birth*</b>	
<b>Medi-Cal CIN</b>	
<b>Preferred Written Language</b>	
<b>Member Email Address</b>	
<b>Member Primary Phone Number</b>	
<b>Member Residential Address</b>	
<b>City</b>	
<b>State</b>	
<b>Zip Code</b>	

<b>Is the member currently experiencing homelessness?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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**SECTION 3 – AUTHORIZED REPRESENTATIVE INFORMATION**

<b>Member has Authorized Representative</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Authorized Representative First Name</b>	
<b>Authorized Representative Last Name</b>	
<b>Authorized Representative Relationship to Member</b>	
<b>Phone Number</b>	
<b>Email Address</b>	
<b>Mailing Address</b>	

**SECTION 4 – CLINICAL INFORMATION**

<b>Primary Diagnosis</b>	
<b>ICD-10 Code</b>	
<b>Secondary Diagnoses</b>	
<b>Primary Care Provider</b>	
<b>Behavioral Health Provider (if applicable)</b>	
<b>Recent Hospitalization Within Past 30 Days</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If Yes, Discharge Date</b>	

**SECTION 5 – SERVICE INFORMATION**

**Request Information**

**Service Start Date:**

**Service End Date:**

**Eligibility Criteria****Molina Enrollment:**

Enrolled in Medi-Cal with Molina

**Member must meet one of the following four (4) criteria:**

Member is prioritized for a permanent supportive housing unit or rental subsidy through CES or a similar system.

Member meets the HUD definition of homelessness or at risk of homelessness AND one of the following:

Has one or more serious chronic conditions or serious mental illness

At risk for institutionalization or requires residential services because of SUD or Serious Emotional Disturbance

Enrolled with ECM

Transition-Age Youth with significant barriers to housing stability

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**Housing Profile**

Current Housing Status:

Experiencing Homelessness

At Risk of Homelessness

Prioritized through CES

Exiting Institution

Other:

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**Housing Navigation Needs**

Check all that apply:

Housing Search Assistance

Housing Application Assistance

Benefits Advocacy

Landlord Engagement

Housing Barrier Resolution

Move-In Coordination

Housing Resource Navigation

Other:

**SECTION 6 – REQUIRED DOCUMENTATION**

Please attach all supporting documentation required for review.

- Coordinated Entry System (CES) Documentation (if applicable)
- Supporting Clinical Documentation (if applicable)
- Additional Supporting Documentation

Additional documentation submitted:

**SECTION 7 – ATTESTATION****Member Consent**

- I attest that the member and/or authorized representative has consented to this Community Supports referral.

**Referral Attestation**

- I attest that the information provided in this referral is accurate and complete to the best of my knowledge.